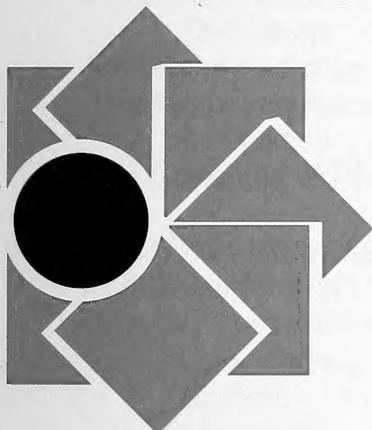


HIV, TB & Infectious Diseases

**The Alcohol and Other Drug Use Connection
A Practical Approach to Linking Clients to Treatment**



Participant Guide, 1998

**Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration**

**In collaboration with
The Centers for Disease Control and Prevention**





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***HIV, TB & INFECTIOUS DISEASES:
The Alcohol and other Drug Abuse Connection***

A G E N D A

8:30 Registration

9:00 Introductions, Overview of Workshop
Case Studies
Personal Introductions
Review Agenda, Format, Goals and Objectives

9:45 The Alcohol and Drug Abuse/Infectious Disease Connection

10:30 B R E A K

10:45 HIV Disease Update

11:15 An Overview of AOD Abuse and Addiction

12:30 L U N C H

1:45 An Overview of Infectious Diseases

3:15 B R E A K

3:30 Tuberculosis Update

4:30 Feedback / Close Day One

***HIV, TB & INFECTIOUS DISEASES:
The Alcohol and other Drug Abuse Connection***

AGENDA Continued

8:45 Review/Preview

9:00 Developing Risk Assessment/Harm Reduction Messages

10:30 B R E A K

10:45 An Overview of Screening and Assessment Methods

Self-Comfort Inventory

12:15 L U N C H

1:30 AOD Screening-Practicum

Infectious Disease Screening-Practicum

2:30 Risk Assessment/Harm Reduction

3:00 B R E A K

3:15 Risk Assessment/Harm Reduction-Practicum

4:15 Legal Issues Surrounding Client Confidentiality: Collaborating in the Provision of Communicable Disease and AOD Abuse Treatment

4:45 Feedback and Evaluation

5:00 Adjourn



Acknowledgments

Development of this "cross-training" workshop for disease intervention specialists (DIS) and alcohol and other drug (AOD) abuse treatment counselors was prompted by the recognition that many clients being treated for chemical dependency are the same patients being seen in clinics for the treatment of sexually transmitted and other infectious diseases. The ability to recognize risk factors for infectious diseases in clients entering or enrolled in alcohol and other drug abuse treatment facilities has been an increasingly important task for counselors and intake workers. Similarly, disease intervention specialists need to be mindful of both obvious and subtle signs of possible alcohol and other drug abuse issues with their patients.

The Center for Substance Abuse Treatment (CSAT) and the Centers for Disease Control and Prevention (CDC) initiated preliminary discussions on the development of a competency-based curriculum. Both agencies conceived of a curriculum that would increase understanding of infectious diseases and alcohol and other drug abuse in the "age of HIV disease", as well as examine attitudes and beliefs of personnel working in AOD abuse treatment programs and public health clinics.

The following individuals have been advocates and key informants in the development of this curriculum:

Edward Morgan (formerly with CSAT) and Duiona Baker (SAMHSA) who first discussed their interest in this project several years ago; Sue Becker (CSAT) who provided oversight on the development of the Treatment Improvement Protocol "Simple Screening Instruments for Outreach for Alcohol and Other Drug (AOD) Abuse and Infectious Disease"; J. Wendell McConnell (formerly with CSAT) who provided profound comments and review of this training package.

Bob Emerson, John Miles, Janet Cleveland, Melanie Duckworth, Brian Mahoney, Wanda Walton, and Beth Wolfe (CDC) who participated in the initial work group and provided feedback and input on curriculum content; Susan Graham (CDC) who provided feedback and suggested revisions on the TB content; Harry Stern and Chris Hayden (CDC) who also provided input into content selection and training design; and Carol Orsini (CDC), who participated in pilot deliveries of the workshop.

A number of HI-TECH International, Inc. employees and consultants have been instrumental in the ongoing development and updating of this curriculum. Jack B. Stein and Glen Fischer designed the initial training format, selected critical content and training methodologies, and developed the initial curriculum. Michael Dunham, Jacqueline Rosario, and Marianne Scippa provided critical feedback and suggestions, materials development, revisions, and production for the final version of the training manuals. Sherrie Smith provided graphics assistance on initial versions of the manual. Niles Comer assisted with the manual format, design and graphics. Glen Fischer and Brian Mahoney conducted the initial pilot deliveries of the workshop. Lori DeLorenzo provided updated materials and field testing.

CSAT produces printed resources titled the **Treatment Improvement Protocol Series (TIPS)** and the **Technical Assistance Publication Series (TAPS)**. These resource materials are designed to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of AOD abuse. Acknowledged clinical, research and administrative experts in the Nation's AOD abuse treatment and public health fields collaborate on these series.

Five **CSAT** publications were utilized in the development of this curriculum package:

- **Treatment Improvement Protocol Series (TIPS): Screening for Infectious Diseases Among Substance Abusers**; Andrea Barthwell, M.D., Consensus Panel Chair and Cynthia L. Gibert, M.D., Medical Consultant and Writer.
- **Treatment Improvement Protocol Series (TIPS): Simple Screening Instruments for Outreach for Alcohol and Other Drug (AOD) Abuse and Infectious Disease**, Ken Winters, Ph.D. and Jonathan Zenilman, M.D., Consensus Panel Chairs.
- **Technical Assistance Publications Series (TAPS): Confidentiality of Patient Records for Alcohol and Other Drug Treatment**, Felix Lopez, Esq.
- **Treatment Improvement Protocol Series (TIPS):Treatment for HIV-Infected Alcohol and Other Drug Abusers**, Peter A Selwyn, M.D., M.P.H., and Steven L. Batki, M.D., Consensus Panel Co-Chairs.
- **Treatment Improvement Protocol Series (TIPS): The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**, David H. Mulligan, Consensus Panel Chair

To receive **TIPS** and **TAPS** publications and updates, write to:

National Clearinghouse for Alcohol and Drug Information
PO Box 2345
Rockville, MD, 20852
(800) 729-6686

CDC publications used in the development of this training package include:

- **Improving Patient Adherence to Tuberculosis Treatment**, revised 1994
- **HIV Counseling, Testing and Referral: Standards and Guidelines**, May 1994
- **HIV PREVENTION COUNSELING: A Training Program**, November 1993

INTRODUCTION

A Brief History of Cross-Training

This Participant Guide is a product of an inter-agency effort initiated by the Center for Substance Abuse Treatment (CSAT), Rockville, MD and the Centers for Disease Control and Prevention (CDC), Atlanta GA. This guide has been developed to assist participants to effectively utilize this "cross-training" workshop along with colleagues in the alcohol and other drug abuse treatment and public health arenas.

The term "cross-training" does not imply that this workshop will train individuals to do somebody else's work. Rather, critical information and skill are being presented to help participants respond to the inter-related health and behavior problems of patients and clients seeking alcohol and other drug abuse treatment and/or public health services (sexually transmitted disease, HIV, tuberculosis, hepatitis, etc.).

It became obvious that a training workshop would be a useful strategy for gaining knowledge, improving skills and increasing sensitivities for counselors and disease intervention specialists as they respond to the inter-related health and behavior problems of patients and clients seeking services.

Rationale for the "Cross-training" Initiative

The development of this training workshop was motivated by the recognition that AOD abuse treatment and public health professionals need to screen for conditions that occur together with high prevalence in some populations. AOD abuse treatment personnel need to be able to identify risk factors for infectious diseases in the individuals in their programs. Similarly, disease intervention specialists working with persons being treated for infectious diseases need to be alerted to signs of possible AOD abuse which influence risky sexual practices.

Many, if not most, of the factors that place an individual at high risk for either substance abuse disorders or infectious diseases also place them at risk for the other of these two problems. For instance, injecting drug users, in addition to being highly likely to have an addiction problem, are also at risk for infection with HIV because of the practice of works-sharing that is common in many communities. Similarly, an individual with STDs may also be likely to have an alcohol or other drug abuse problem, owing to the sexual disinhibition that is often produced by AOD abuse, or the selling of sex for drugs which may have led to high-risk sexual encounters.

Ultimately, it is hoped that screening for both AOD abuse and infectious diseases concomitantly will facilitate access to health care for at-risk individuals by promoting early identification of these problems. In addition, the appropriateness and specificity of treatment placement can be improved when a co-morbid client is accurately screened. For example, individuals with infectious diseases can receive appropriate intervention, such as preventive therapy for potential latent TB infection in HIV-infected clients, in the AOD program. Another alternative would be to refer these individuals for appropriate

treatment of the infectious condition. The risk of illness and spread of disease to the community could thus be reduced.

In response to the issues discussed above, this workshop targeting both disease intervention specialists and substance abuse treatment staff was developed. The overall goal of the workshop is to enhance knowledge and skills required by both disciplines, as well as to explore attitudes and sensitivities that could pose barriers, in response to the inter-related health and confidentiality issues faced by clients and service providers.

This "cross-training" workshop is unique in its attempt to bring both public health and AOD service providers into a shared learning environment. Through this process, it is hoped that critical knowledge and skills can be transferred, and a climate created for building important linkages in the community.

How to Use this Manual

The **Participant Guide** has been designed to promote and document active participation in this two-day cross-training workshop. With narrative text, worksheets and case studies, this training manual enables you to generate a personalized reference resource for subsequent use in your agency . As such, it is not a "stand-alone", self-instructional guide or text of current knowledge of AOD abuse and infectious diseases. Rather, it can assist in the development of critical competencies learned during the training experience.

The Participant Guide contains five units of core training material and a sixth unit of professional development guidelines. Reproductions of important visuals and other outlines that document presentations are included and provide space for taking notes during the training. Full instructions and case profiles for hands-on skill development are included.

Unit I

The Alcohol and Other Drug Abuse/Infectious Disease Connection

The Alcohol and Other Drug Abuse/Infectious Disease Connection

For many years now, the Nation has been challenged by the epidemic of AOD use. During the last decade, this challenge has been further complicated by the appearance of HIV disease. Recently, the "twin epidemics" of substance abuse and HIV disease present themselves in association with a resurgence of tuberculosis and sexually transmitted diseases.

Since the early years of the HIV disease epidemic, a clear link between *injecting drug use* and HIV infection has been established. In many areas of the country, repetitive use and exchange of hypodermic needles has already directly infected many current or former IDUs--in and out of treatment--and their sexual partners.

As the graphic on the next page illustrates, the risks for HIV are linked to AOD use by:

- ➡ damaging physical health and increasing susceptibility to HIV infection or disease progression;
- ➡ impairing judgment, increasing unsafe sexual activity, or causing blackouts (drug induced memory loss) leading to risky behaviors;
- ➡ engaging in high-risk, unsafe sex practices in exchange for drugs/drug money.

Indirect connections between AOD use and HIV and other infectious diseases may play a greater role in their spread than the better understood "direct" link with injection drug use. Alcohol can certainly impair judgment. A person who values abstinence or "knows" about safer sex may take no precautions if they have sex under the influence of alcohol.

Individuals who use the cocaine derivative commonly known as crack, and methamphetamine, may have multiple sex partners while "under the influence" and may also have indiscriminate sex to obtain their drug of choice or other desired drug, or money to buy these drugs.

Syphilis rates remains remarkably high among crack users. Many health departments report large numbers of heterosexual men being treated for secondary syphilis, and then testing positive for HIV.

IDUs often develop hepatitis from the practice of sharing works--the syringe, needle, cooker, cotton, water.

AOD users who may have been incarcerated or homeless have a possible risk of contracting tuberculosis through repeated exposure to contaminated environments.

SUBSTANCE ABUSE

DIRECT TRANSMISSION
PWAs (have IDU
histories)

INDIRECT TRANSMISSION

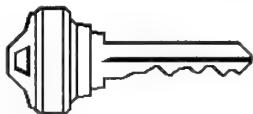
Heterosexual Partners
with HIV/AIDS
Babies with HIV/AIDS

CO-FACTOR
Vulnerability to Infection
Disease Progression

BEHAVIORAL IMPAIRMENT

Disinhibition/Blackouts
Sex for \$/Drugs
Hypersexuality
Interactive Addiction

KEY FACTS: Alcohol/Other Drug Use and HIV/Other Infectious Diseases



- ❖ Among the estimated 1.5 million people who inject drugs in the United States, the rate of HIV infection has increased dramatically in the past decade.
- ❖ Approximately 33 percent of all new AIDS adult/adolescent cases reported through December, 1997, are attributable to injection drug use. (CDC HIV/AIDS Surveillance Report, Vol. 9, No.2)
- ❖ Of the pediatric AIDS cases related to a mother with/at risk for HIV infection, 53 percent are related to maternal exposure to HIV through injection drug use. (CDC HIV/AIDS Surveillance Report, Vol. 9, No. 2)
- ❖ 44 percent of all female adult/adolescent cases acquired heterosexually were sexual partners of IDUs. (CDC HIV/AIDS Surveillance Report, Vol. 9, No. 2)
- ❖ There has been a steady increase in the incidence of hepatitis B, despite the availability of a vaccine since 1982. Most of the increase is attributed to injection drug use (CDC Hepatitis Surveillance Report, 1996). Hepatitis C among IDUs is also high.
- ❖ The greatest rise in syphilis has been among men and women who are smoking crack cocaine. Smoking crack cocaine has been shown to be associated with increased sexual activity with multiple sex partners, and the concomitant spread of syphilis. The combination of smoking crack and engaging in risky unprotected sex has also contributed to the spread of HIV, particularly among women who exchange sex for drugs or money. (Edlin, B., Faruque, S., et.al., 1994 *Intersecting Epidemics*, New England Journal of Medicine, 33, 1422-1427)
- ❖ Only 1 in 7 individuals experiencing problems with AOD use/abuse may seek treatment. Yet these individuals are seen daily in sexually transmitted disease clinics, public health clinics and hospital emergency rooms.
- ❖ From 1985-1996, there has been a significant rise and then fall in the number of new cases of tuberculosis. Injection drug use accounts for almost 4 percent of all current cases of TB. Additionally, many current cases are found among HIV-infected persons (CDC, Reported Tuberculosis in the United States, 1996).

HIV DISEASE UPDATE

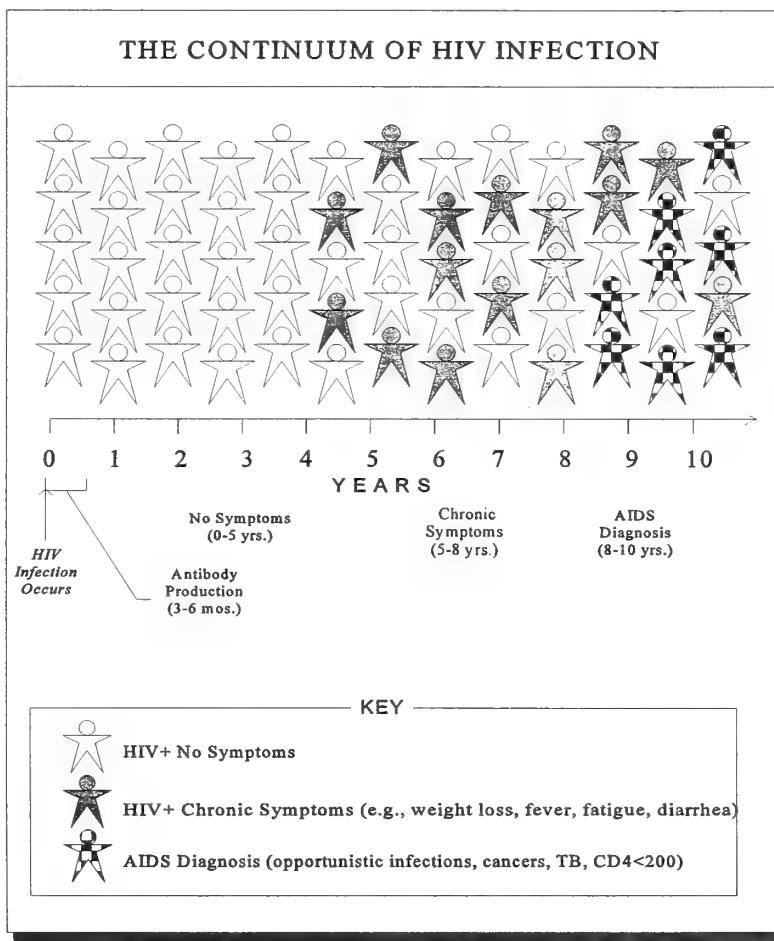
Infection with the human immunodeficiency virus (HIV) is usually associated with a progressive disease process. The clinical spectrum ranges from asymptomatic infection to acquired immunodeficiency syndrome (AIDS). Many persons with HIV disease are unaware that they are infected.

HIV is spread from person to person by three well-recognized routes. The overwhelming majority of cases are *transmitted sexually*, where there is exposure to body fluids such as semen, blood and vaginal or cervical secretions. Other cases are spread by *parenteral transmission* (either through transfusion of contaminated blood or blood products or through injection with a blood-contaminated needle or syringe) or by *perinatal transmission*, which may occur *in utero, intrapartum, or through breast-feeding*.

The graphic to the right depicts the continuum of HIV disease.

An important breakthrough in HIV treatment includes FDA approval of *protease inhibitors*, a new class of antiretrovirals that are considered the most therapeutic agents for HIV to date. These drugs have shown significant results in the treatment of HIV infection-increased CD4 and decreased viral load level-when taken as prescribed. Combination antiretroviral therapy has influenced the marked decline in both the occurrence of AIDS-defining opportunistic illnesses among infected persons and the number of overall deaths from AIDS.

Underdosing, non-adherence, or partial adherence with dosing regimens for these drugs may result in development of a resistant strain(s) of HIV that will not be susceptible to treatment with protease inhibitors. Patients must be aware of the need to take the complete dose to lessen the risk of potential drug resistance. Further, patients should not modify the dosage in any way to "extend" their prescription.

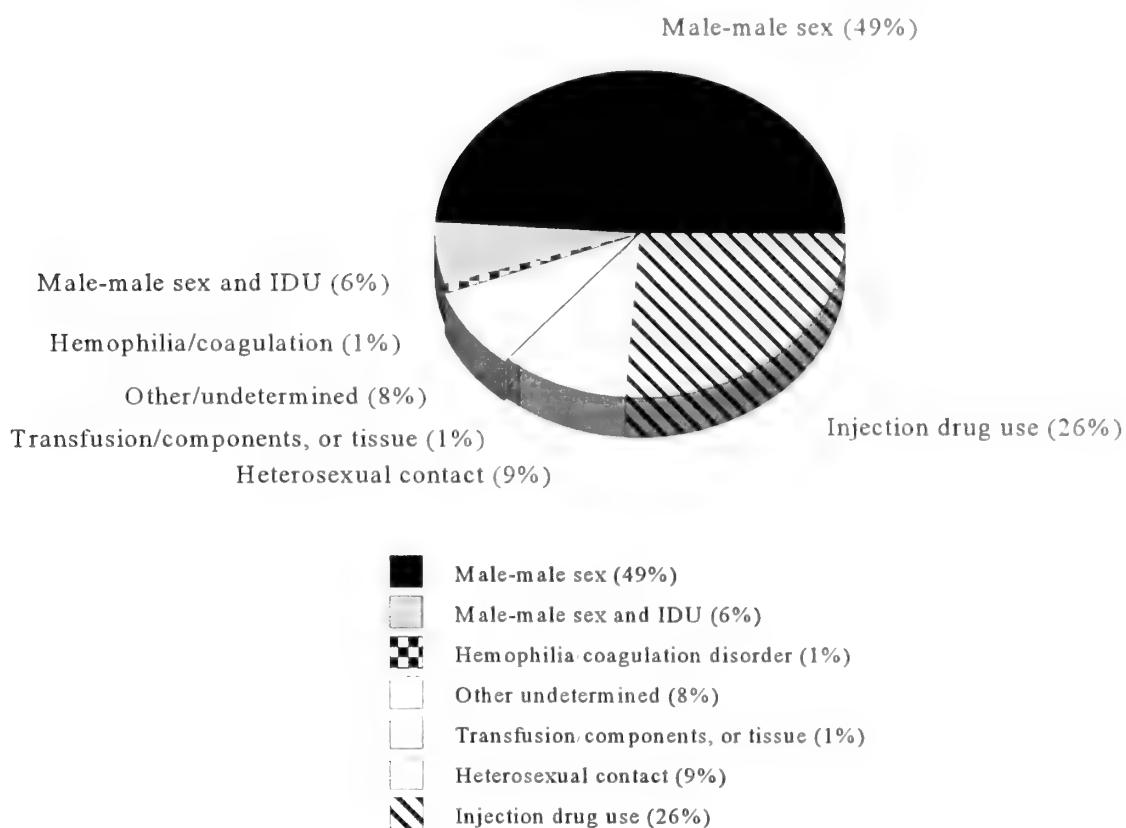


Trends

Data presented in CDC's *HIV/AIDS Surveillance Report: Year-end Edition* (Vol.9, No.2) mid-year 1998, show that men who have sex with men continue to be most severely affected by the AIDS epidemic. However, comparisons between AIDS cases reported in 1997 and in earlier years indicate that women, African-Americans and Hispanics, and persons with heterosexually acquired HIV infections account for the dynamic growth in the epidemic. Injecting drug use and sex with at-risk partners, especially among heterosexuals and young homosexual/bisexual men, continues to challenge HIV prevention programs.

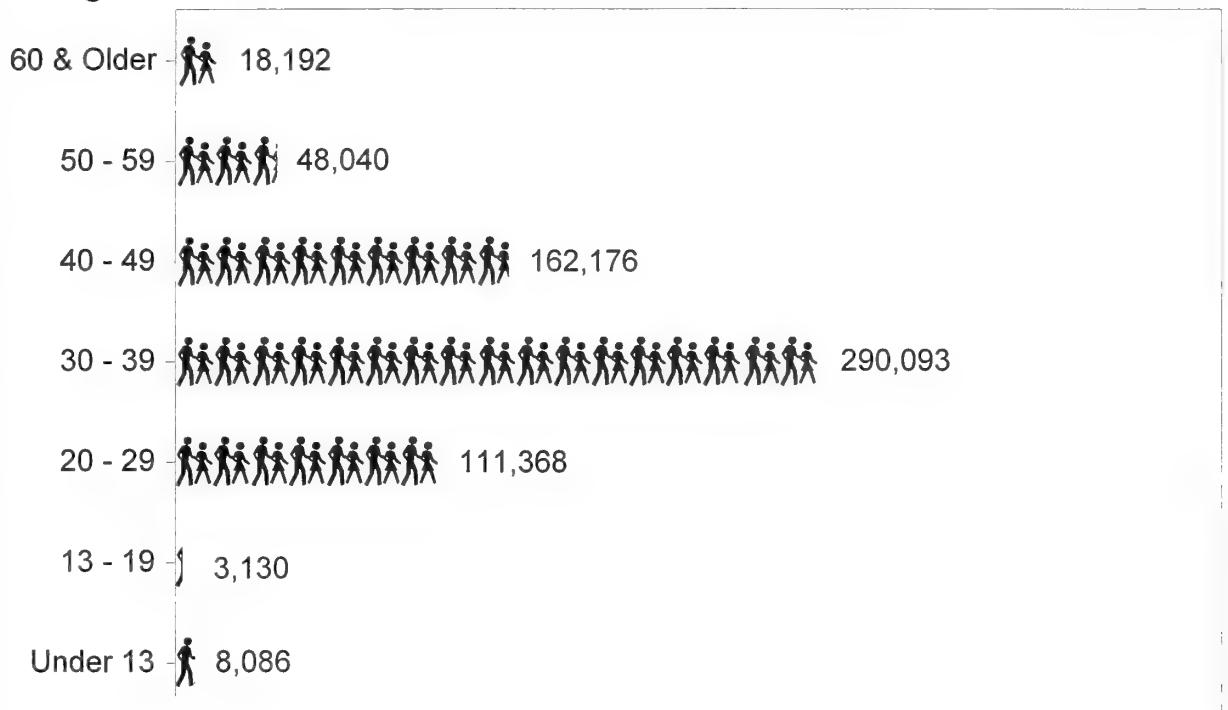
Several graphics on the next several pages illustrate key trends in American AIDS cases reported in 1997.

Distribution of Americans with AIDS by Risk Exposure, Reported as of June 1997



Distribution of Americans with AIDS by Age

Age



Source: CDC HIV/AIDS Surveillance Report, 6/98

General Clinical Manifestations of HIV Disease

General clinical manifestations often associated with HIV infection are shown below. Persons with a history of tuberculosis, viral hepatitis B or C, or any sexually transmitted disease should be counseled and tested for HIV. An HIV-infected person is more likely than a non-HIV-infected person to develop serious bacterial infections, especially pneumonia and tuberculosis. Any patient with such a history should receive HIV Prevention Counseling.

The associated signs and symptoms detailed below, are neither unique to HIV disease nor diagnostic of HIV disease. There can be medical complications of AOD use that may effect diagnosis of AOD abusers with HIV infection. (See chart on next page.)

General Clinical Manifestations

- ⌚ Fever
- ⌚ Night Sweats
- ⌚ Unexplained weight loss; loss of appetite
- ⌚ Malaise
- ⌚ Cough, shortness of breath
- ⌚ Visual changes, including visual field defects
- ⌚ Recurrent or persistent sinusitis
- ⌚ Abdominal pain, diarrhea
- ⌚ Persistent, recurrent Candida vaginitis (women)
- ⌚ Cervical/vaginal dysplasia
- ⌚ Neurologic conditions--headaches; difficulty in concentrating; short-term memory loss; pain in extremities, especially feet; photosensitivity; focal neurologic deficits (problems with balance, muscle strength, grip)
- ⌚ Easy bruising or abnormal bleeding associated with low platelets

Dermatologic Conditions

- ⌚ Folliculitis
- ⌚ Molluscum contagiosum
- ⌚ Genital warts
- ⌚ Herpes simplex: oral, genital, rectal
- ⌚ Herpes zoster (shingles)
- ⌚ Fungal dermatitis
- ⌚ Seborrheic dermatitis
- ⌚ Psoriasis
- ⌚ Rash
- ⌚ Kaposi's Sarcoma

Oral Cavity/Mouth

- ⌚ Oral lesions; periodontitis, gingivitis
- ⌚ Thrush: Candida infection of tongue, throat
- ⌚ Kaposi's Sarcoma, especially roof of mouth

Findings of these signs or symptoms should alert the care giver to the possibility of HIV.

Medical Complications of Alcohol and Other Drug Use That May Affect Differential Diagnosis Among Substance Abusers with HIV Infection

| Symptoms | Possible Diagnoses | | Behavioral/Medical Complications |
|--------------------------|--------------------------------------|--|----------------------------------|
| | HIV-Related | AOD-Related | |
| 1. <i>Constitutional</i> | | | |
| Anorexia | HIV infection | Cocaine or | |
| Weight loss | Mycobacterium | methamphetamine use | |
| Fever | Cytomegalovirus | Tuberculosis | |
| Night sweats | Tuberculosis | Opiate or Alcohol withdrawal | |
| Diarrhea | Parasites | Opiate or Alcohol withdrawal | |
| 2. <i>Pulmonary</i> | | | |
| Chest pain | Bacterial pneumonia | Cocaine use | |
| Cough | PCP (pneumonia) | Tobacco/crack use | |
| Shortness of breath | Tuberculosis | Aspiration pneumonia | |
| 3. <i>Neurologic</i> | | | |
| Altered mental state | HIV infection with brain involvement | Intoxication/withdrawal from most substances of abuse, including: Heroin Cocaine Alcohol Benzodiazepines | |
| Psychosis | Toxoplasmosis | Acute use of methamphetamine, phencyclidine, or cocaine | |
| Seizures | HIV infection in brain | Alcohol or benzodiazepine withdrawal | |

AIDS Associated Clinical Syndromes

Opportunistic infections can be classified under the following syndromes (sets of symptoms that characterize a disease):

1. Pulmonary Syndromes
 - a. Pneumocystis carinii pneumonia (PCP), a very common, treatable opportunistic infection.
 - b. M. Tuberculosis (TB), significantly increased risk in persons with HIV disease for both the primary *and* reactivation of disease.
 - c. Mycobacterium avium (MA), an atypical mycobacterium, in the same family as tuberculosis, resistant to many antibiotics.
2. Central Nervous System (CNS) Syndromes

CNS syndromes can cause headaches and/or altered mental states.

 - a. Toxoplasma gondii (toxoplasmosis), in HIV-infected individuals, can cause cerebral abscesses.
 - b. Cryptococcal meningitis can cause severe headaches.
 - c. Progressive multifocal leukoencephalopathy (PML), an unusual CNS infection, often causing a dementing, debilitating illness, in which patients gradually, or sometimes not so gradually, progress to a vegetative state.
3. Diarrheal Illness
 - a. Cryptosporidium, bowel infection with severe, persistent diarrhea.
 - b. Enteric pathogens, including salmonella.
 - c. Parasites.
 - d. C. difficile associated colitis.
4. Viral Illness
 - a. Cytomegalovirus (CMV) infection, severe disease, retinitis can cause blindness.
 - b. Severe, persistent herpes simplex infections.
5. Tumors
 - a. Kaposi's sarcoma, disseminated skin involvement, visceral involvement.
 - b. Non-Hodgkin's lymphoma, includes primary lymphoma of the brain, disseminated large cell lymphoma; often aggressive and difficult to treat.
 - c. Abnormal cervical cytology frequent in women, related to human papilloma virus (HPV) infection; probable increased risk of cervical cancer.

HIV PREVENTION COUNSELING

Counseling provides a critical opportunity to assist the client or patient in identifying her/his risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate behavioral risk. Counseling prior to HIV testing (pretest) should prepare the client or patient for receiving, understanding and managing her/his test result.

Persons seeking care for sexually transmitted infections, family planning, childbirth or substance abuse are counseled about HIV testing in an attempt to reduce their risk of HIV transmission. The primary public health purposes of counseling and testing are to assist uninfected individuals to initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others.

HIV Prevention Counseling can enable counselors to apply effective and efficient client-centered communication and counseling skills to:

1. Assist a client to improve her/his self-perception of risk;
2. Support behavior changes the client has already attempted;
3. Negotiate a realistic and incremental plan for the client or patient to reduce her/his risk;
4. Support the patient or client in making a decision about testing and preparing for the result; and,
5. Assist the client who tests for HIV to begin to integrate the result emotionally, behaviorally, and socially.

Public Health Service (PHS) guidelines for HIV counseling and voluntary testing of pregnant women recommend that *all* pregnant women receive counseling on the importance of the HIV test.

In February 1994, the National Institutes of Health (NIH) announced findings of a study sponsored by the Pediatric AIDS Clinical Trials Group (ACTG) which found that a regimen of Zidovudine (ZDV or AZT) reduced perinatal transmission of HIV by two-thirds in infants whose mothers met eligibility criteria. THE ZDV perinatal regimen, administered within a comprehensive care system, is currently considered a standard of care for pregnant women with HIV; however, the decision to follow the regimen will ultimately be made by the woman. It is important to note that the National Institute on Allergy and Infectious Disease (NIAID) instituted studies in 1996 exploring the possible connection between development of certain cancers in infants and toddlers who had been exposed to AZT therapy in utero.

Unit 2

An Overview of Alcohol and Other Drug Abuse

AN OVERVIEW OF ALCOHOL AND OTHER DRUG ABUSE

Alcohol and other drug abuse continues to be one the greatest public health threats in the United States. While many people think that the 1960's were the glory days of drugs, with the media focusing on young and old trying illicit drugs such as marijuana and hallucinogens like LSD, mescaline, and psilocybin, AOD use had taken its toll for many years prior. In fact, for over one hundred years, Americans have become addicted to or dependent on any number of substances.

In the mid-1800's, with the advent of the syringe, Civil War soldiers were able to self-administer morphine. Those who became addicted to morphine were said to have "soldier's disease". Numerous tonics and elixirs were available to the general public, with women frequently the buyers. These elixirs often contained cocaine and caffeine, drugs which can cause psychological dependence and physical addiction. Coca-cola, invented in 1866, contained caffeine and cocaine, with the cocaine not being removed until 1906!

The availability and consumption of alcohol has had a stormy history in the US. Temperance movements of the late 1800's sought to ban alcohol and viewed users as evil and immoral souls to be saved. Alcohol consumption became a legal problem in the 20th century when prohibition made it illegal to make, distribute or purchase alcohol. More alcohol was consumed during Prohibition than the 10 years prior to or immediately after. Not until alcoholism was seen as a disease, with recognizable symptoms and a fairly predictable prognosis, did the **moral-legal** view tend to diminish.

Today AOD abuse is on the increase. Since 1994, heroin has been making a "comeback", although in many communities it has remained, along with alcohol and tobacco, a drug of preference. Tobacco is now being regarded as a major killer, and perhaps the number one drug problem in the US.

Perhaps most important is the role that AOD abuse plays by increasing risky behaviors and susceptibility to infectious diseases such as HIV, hepatitis and tuberculosis. This section of the workshop will provide an overview of AOD dependence, an examination of models of addiction and dependence, a focus on the biological, social, psychosocial and behavioral aspects of AOD, and a look at some key concepts in pharmacology of prominently used drugs.

Alcohol and other drug abuse contributes to the top ten killers in the US, as well as many other illnesses and conditions. In the space provided below, list the drugs which may contribute to these conditions.

| ILLNESS/Condition | DRUGS which may contribute |
|-------------------------|----------------------------|
| Heart disease | |
| Cancer | |
| Stroke | |
| Pneumonia, Influenza | |
| Emphysema, lung disease | |
| Accidents | |
| Diabetes | |
| HIV/AIDS | |
| Chronic liver disease | |
| Violence | |
| Depression | |
| Suicide | |
| Eating Disorders | |

AOD Use Facts

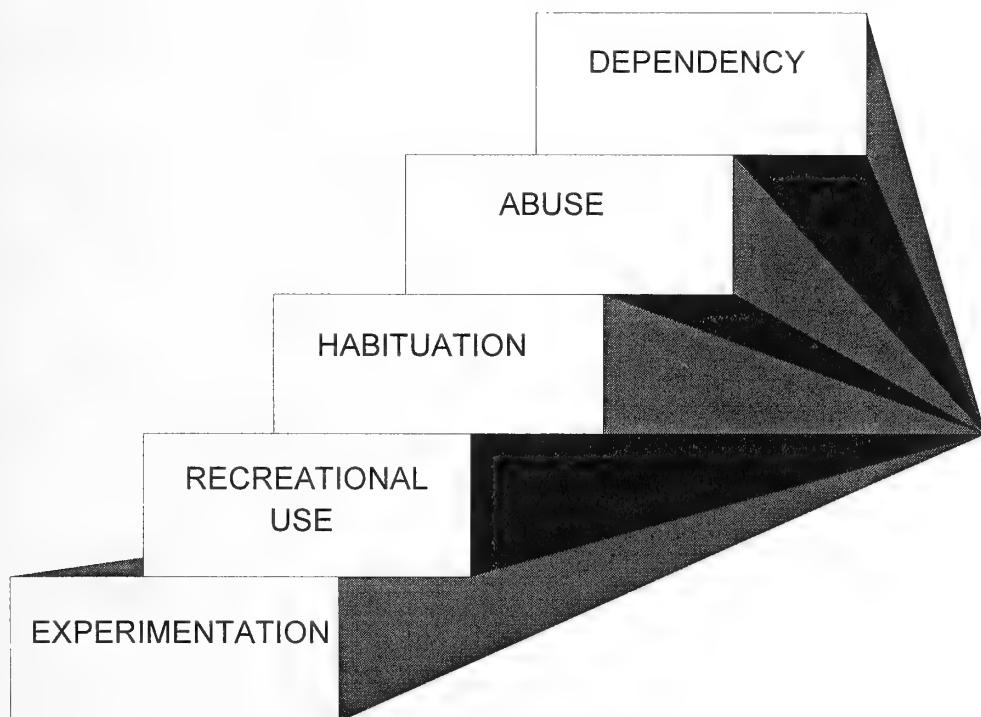
Alcohol and other drug abuse are closely linked to both mental health and social health issues¹.

- National survey indicates that 111 million Americans age 12 and older (52 percent of the population) had used alcohol within the past month. An estimated 32 million engaged in binge drinking (defined as "the consumption of five or more drinks in a row on at least one occasion.") About one third of high school seniors and 42 percent of college students reported at least one occasion of binge drinking within the previous two weeks. (**The 1995 National Household Survey on Drug Abuse**).
- An estimated 12.8 million Americans are current illicit drug users, meaning they had used an illicit drug in the month prior to the interview. (**The 1995 National Household Survey on Drug Abuse**).
- About one out of every ten newborns in the U.S. - 375,000 per year- is exposed prenatally to one or more drugs. Among women age 15 - 44 who are not pregnant and have no children, 9.3 percent are current illicit drug users. Approximately 2.3 percent of pregnant women are current illicit drug users; however, among women who recently gave birth (not currently pregnant, and have a child under two years of age) have a use rate of 5.5 percent, suggesting that many women resume their drug use after giving birth. (**The 1995 National Household Survey on Drug Abuse**).
- The U.S. has the highest rate of illicit drug use among adolescents of any industrialized nation. Nearly one-half of all high school students have used illicit drugs. Between 1994 and 1995 there was an increase in the rate of past month illicit drug use among youth from 8.2 percent to 10.9 percent, indicating the rate has doubled since 1992. (**The 1995 National Household Survey on Drug Abuse**).
- 500,000 persons per year are injured in alcohol-related automobile accidents. 19,000 alcohol-related traffic deaths occur each year.
- Alcohol and other drug use is associated with approximately 50 percent of spouse abuse cases, 49 percent of homicides, 38 percent of child abuse cases, and 52 percent of rapes.
- Each year in this country, over one million people are arrested on drug-related charges. In 1993, Americans spent an estimated \$49 billion on illegal drugs including cocaine, heroin, and marijuana. Of 712,000 prison inmates interviewed in 1991, 31 percent reported being under the influence of drugs when they committed the crime, and 17 percent reported they were trying to get money for drugs when they committed the crime. (**The National Drug Control Strategy, 1996**).

¹ From the Center for Substance Abuse Prevention's *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms*, October 1992.

As has been stated, the use of AOD impacts many Americans. We know that as many as 20 million Americans smoke marijuana at least once a month. Annual cocaine users number over 12 million. Several million others use tranquilizers, sedatives and stimulants without medical supervision. These numbers are, of course, dwarfed by the 125 million people who use alcohol and 61 million who use tobacco products. Perhaps as many as 10-12 percent of people in the total population have an alcohol or drug dependency problem. On the next few pages are *several models and explanations* for why some people maintain or stop AOD use at one level while others may progress on to problems severe enough to require treatment.

LEVELS OF SUBSTANCE USE



Definitions

Substance abuse can be defined as the use of any substance (licit or illicit) which brings about physical, mental, emotional or social impairment.

- **Non-use; abstinence:** absence of any drug use.
- **Experimentation:** (also referred to as early or social use): use without the presence of any social, financial, interpersonal, or legal problems. Experimentation occurs most often in response to a variety of external influences which frame use of AOD in a socio-cultural context.
- **Recreational use:** traditionally, the use continuum has included a place for this category. However, the current prevailing perspective notes that if a drug is classified as a controlled substance, then "recreational" use is theoretically impossible, as there are immediate potential legal consequences for procuring and using the substance. Alcohol by definition can be used recreationally by adults without consequence.
- **Habituation:** (also referred to as regular, problem, or heavy use): use which is integrated in the user's lifestyle, demonstrated by discernable patterns of use. At this stage users may begin to experience some impact of their use on the general functioning of their lives. This may include the onset of various medical, legal, social, financial, occupational, or personal problems.
- **Abuse:** (also referred to as daily preoccupation or early addiction): use at this stage is often accompanied by various combinations of problems, discernable patterns of impairment of life functioning, and the onset of some physical or psychological withdrawal symptoms, if use is discontinued.
- **Dependency:** (also referred to as chronic or late addiction): at this stage use is accompanied by multiple problems and potentially serious medical complications, including significant withdrawal symptoms, whether physical or psychological.
- **Relapse:** Most theorists agree that people who have developed dependency problems can be treated successfully. However, even when treated successfully, there is a significant recurrence of symptoms. The term "Relapse" is used to define this process involving the return to use after a period of abstinence.

Models of Addiction and Dependence

As discussed previously, AOD abuse is one of America's biggest problems. Numerous surveys cite AOD abuse as a top concern for school officials, criminal justice personnel, city administrators and parents. Unfortunately, society, once it recognizes a problem, clamors for quick and easy solutions, no matter how complex the problem.

There are three basic elements to be considered when exploring the use of any drug, legal or illegal, medically prescribed or used "recreationally":

- **The Substance**

Focus on the **substance** has led to attempts at prohibition and interdiction. Classify drugs as good **or** bad and try to keep the bad drugs away from people. Consequently, people who use the bad drugs are seen as being bad people and often are the ones seized. Prohibition of alcohol and numerous wars on drugs have been attempts to keep AOD away from people.

- **The Individual Who Uses It**

Psychologists, social workers and counselors tend to focus on the **individual**. Individuals are seen as extremely complex and variable. AOD use is viewed as simply one component of human behavior. AOD becomes but one term in the human equation.

- **The Social and Cultural Context in Which the Drug Use Occurs**

To the social scientist, variations in the **social and cultural context of AOD use** are the complex factors. Cultures and subcultures define and respond to AOD use in different ways. Reasons for AOD use are sought in such factors as institutional failure, social and economic conditions, and societal responses to problems associated with AOD use.

Major models used to view AOD use and abuse have been applied historically in the development of treatment and public policy:

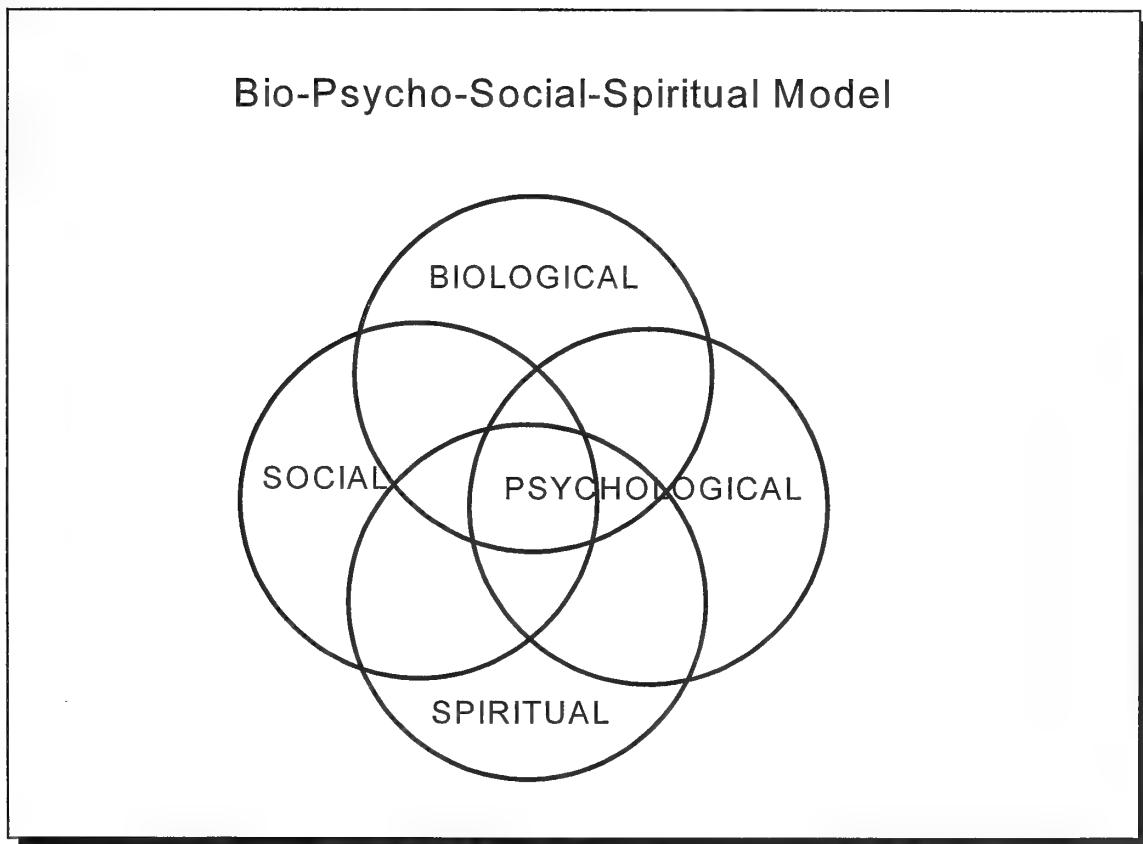
- **Moral-Legal Model:** stresses that addiction is a result of the user's personal weakness and the user should be punished for actions via laws and regulations.
- **Medical-Disease Model:** advocates for recognizing a biochemical foundation to addiction, and focuses on the drugs causing concern and defines them as dependence-producing and potentially lethal.
- **Psycho-Social Model:** explores the interpersonal and intra personal roots of addiction. Drug use and drug-user are the complex, dynamic factors and the major points of intervention. In this context an additional model has come to the fore recently-- the **Behavioral Model**, which views addiction as a learned behavior that can be unlearned.
- **Socio-Cultural Model:** underscores the importance of one's social environment and the impact that the peer group has on development of values and beliefs.
- **Bio-Psycho-Social Model:** a comprehensive model that views addiction as a complicated problem involving numerous biological, behavioral, psychological, social, and environmental factors.

The Bio-Psycho-Social Aspects of AOD Abuse

A holistic approach to understanding AOD abuse can be found in the bio-psycho-social model of human functioning. Each of these three aspects is important in understanding human behavior. AOD abuse, as a form of human behavior, must be viewed in the context of these factors.

The extent to which each aspect--biological, psychological, and social--affects behavior differs for each individual. For some people, psychological factors such as low self-esteem may play a large role in AOD abuse. For other people, biological factors such as genetic predisposition may play a larger role.

While each of the three aspects will be presented in turn, keep in mind that they are interconnected and, together, make up the human experience. The graphic below cites a **spiritual** aspect of AOD abuse as well. Spirituality in AOD treatment is presented in non-religious and theistically neutral philosophical terms. Twelve Step programs (e.g., Alcoholics Anonymous, Narcotics Anonymous, et. al.) rely heavily on spiritual approaches to AOD abuse treatment and recovery.



- **Biological Aspects**

When people use alcohol or other drugs, the biochemical impact of the drug is mediated by individual characteristics such as their genetic predisposition as well as overall health, body weight, age and gender.

- Complexity of biochemical system
- Role of neurotransmitters
- Examples of neurotransmitter imbalances
- Examples of biological factors in substance abuse

- **Psychological Aspects**

The field of psychology is concerned with understanding human thoughts, feelings and behaviors. Certain psychological processes enable the individual to cope with reality and to relate to the self and others. Since all psychological activity is derived from a balance of chemical interactions in the brain, the use of AOD interferes with the regulation of the mental processes important in normal psychological functioning.

- Developmental experiences
- AOD abuse as an adaptive response
- Risk factors for AOD abuse--co-morbidity/psychiatric disorders and psychological adjustment
- Examples of psychological factors in AOD abuse

- **Social Aspects**

Factors such as societal attitudes toward AOD use, socioeconomic conditions, work pressures and family relationships can influence AOD use.

- Societal attitudes
- Socioeconomic conditions
- Work pressures
- Family relationships
- Examples of AOD abuse as a result of social factors

Definitions of AOD Dependence

Diagnostic and Statistical Manual of Mental Disorders - IV

The *Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV)* notes that a formal "diagnosis" of AOD dependence is now made if at least three of the following statements are true. These signs indicate an increased loss of control:

- The substance is taken in larger amounts or over a longer period than the person intended.
- There is a persistent desire or unsuccessful efforts to stop.
- The person spends a great deal of time trying to get the substance (e.g., robberies/hustling to get money), taking it or recovering from its effects.
- Using AOD disrupts important social obligations and/or work activities.
- The person continues to use AOD despite knowing that it is causing problems (e.g., drinking even though it makes an ulcer worse).
- There is a marked tolerance: the person needs increased amounts of AOD to become intoxicated or experiences a marked reduction in the desired effect if using the same amount.
- There are withdrawal symptoms.
- The AOD is taken to avoid the withdrawal symptoms.

American Society for Addiction Medicine

- Addiction/dependence is a complex interaction of physical, emotional, psychological, socio-cultural, and economic variables, characterized by compulsion, loss of control, and continuation of use despite adverse consequences.

National Institute on Drug Abuse

- Addiction is a chronic relapsing disorder of the brain expressed in behavioral ways and in a social context (characterized by the repeated, compulsive seeking or use of a substance despite adverse social, psychological, and or physical consequences). A wide range of substances, both legal and illegal, can be abused addictively. The addiction process is activated by the interaction of AOD with the *reward system* in the brain, and has an impact on the concentration of neurotransmitters in the central nervous system.

Video Presentation

Drug Abuse and the Brain, National Institute on Drug Abuse Videotape Series

(Available through the National Clearinghouse for Alcohol and Drug Information, Videotape Resource Program, 1(800)729-6686).

This video provides a detailed review of the biological basis for drug addiction. Topics include how the “reward system” in the brain operates, and how drug use can cause fundamental changes in how the brain operates.

NOTES:

Key Concepts of Pharmacology

- **Routes of administration:** Drugs may be ingested orally, applied topically and to the mucosa, injected, or inhaled.
- **Metabolism:** this concept addresses how the body breaks down and disposes of the drugs within the system.
- **Testing for the Extent of Drugs in the Body:** Urine testing is the most commonly applied method, and tests may be conducted using breath, blood, breast milk, meconium, and hair. Most tests screen for the presence of drug metabolites, or the products of metabolism left in the system once the drug is deactivated.
- **Homeostasis:** maintenance of bodily functions within a certain range (e.g., temperature, blood pressure, salinity, etc.)
- **Potentiation:** (or, synergy) a phenomenon wherein two or more substances interact in the body to produce an effect greater than the sum of the effects of each substance taken alone or in tandem-essentially multiplying the effect of the drug.
- **Tolerance:** a change in the relationship between the drug and the effects the drug produces; a state of decreased responsiveness to the pharmacological action of a drug resulting from prior use of that drug.
- **Rebound:** can be seen as the central nervous system's response to the discontinuation of a drug. The central nervous system will respond with generally an opposite reaction to the effect of the drug used.
- **Cross-tolerance:** among certain pharmacologically related drugs, a tolerance built up to the effects of one will carry over to the others.
- **Poly-dependence:** dependence upon multiple drugs simultaneously.
- **Withdrawal:** withdrawal symptoms occur when a physically dependent person stops using a drug. Physical and psychological dependence can occur independently of one another.

Physical dependence: an altered or adaptive physiologic state produced in an individual by the repeated administration of a drug, and revealed only when the drug is abruptly discontinued.

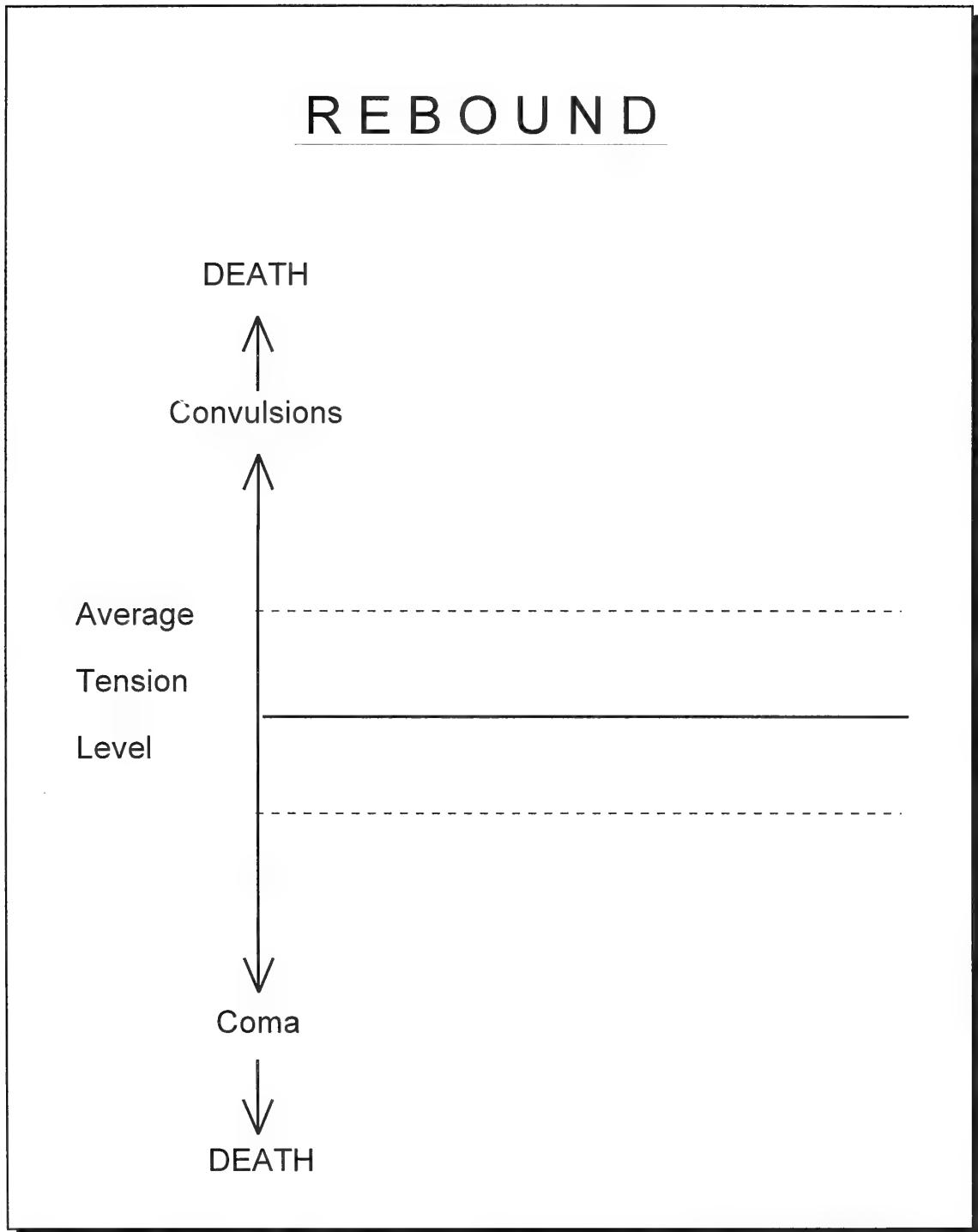
Psychological dependence: characterized by an emotional or mental drive to continue taking a drug whose effects the user feels are necessary to maintain a sense of optimal well-being.

- **Agonist/Antagonist Drugs:** Act on receptor sites in the brain to either stimulate a biological response similar to another drug (e.g., the agonist Methadone mimics the neurological effects of heroin while blocking euphoria and withdrawal), or to block the action of another drug (e.g., the antagonist Naloxone blocks the neurological effects of heroin).

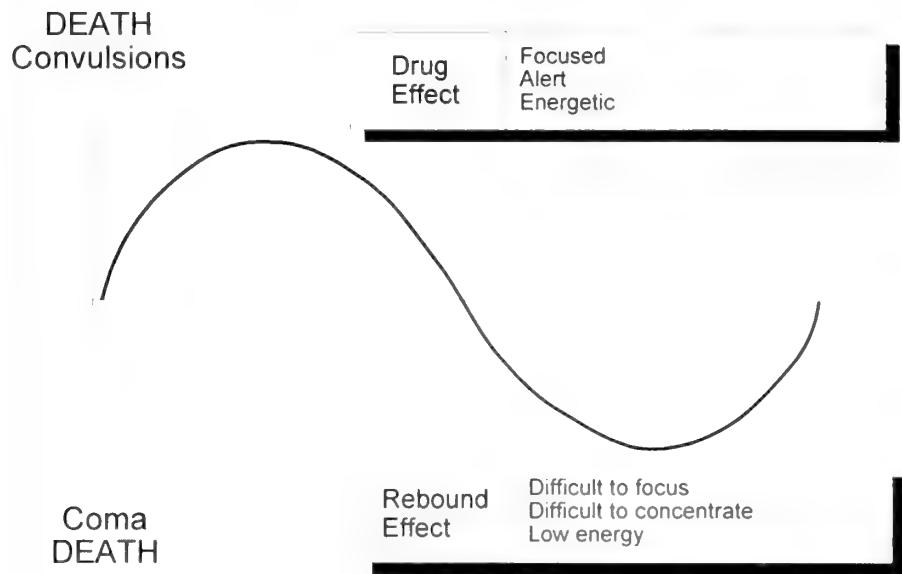
Drugs of Abuse: Use and Effects

| Drug Classification | Drug Type | Methods of Administration | Possible Effects | Overdose Effects | Withdrawal Syndrome |
|---------------------|-----------------------|--|---|--|--|
| Stimulants | Cocaine | <u>Sniffed, smoked, injected</u> Oral, injected | Increased alertness, excitation, euphoria, increased pulse rate and blood pressure, insomnia, appetite loss | Agitation, increased body temperature, hallucinations, convulsions, possible death | Severely depressed mood, prolonged sleep, apathy, irritability, disorientation |
| | Amphetamines | | | | |
| | Methamphetamine | | | | |
| | Phenmetrazine | | | | |
| Depressants | Alcohol | <u>Oral</u> | | | |
| | Barbiturates | <u>Oral, injected</u> | | | |
| | Methaqualone | | | | |
| | Benzodiazepines | | | | |
| Narcotics | Opium | <u>Oral, smoked</u> | | | |
| | Morphine | <u>Oral, injected</u> | | | |
| | Codeine | <u>Oral</u> | | | |
| | Heroin | <u>Injected, smoked</u> | | | |
| Hallucinogens | Methadone | <u>Oral, injected</u> | | | |
| | Other Narcotics | | | | |
| | LSD | Oral | | | |
| | Psilocybin | | | | |
| Cannabis | Mescaline, peyote | | | | |
| | Amphetamine variants | | | | |
| | Phencyclidine | | | | |
| | Marijuana | <u>Smoked</u> | | | |
| | Tetrahydro-cannabinol | <u>Oral</u> | | | |
| | Hashish | <u>Smoked</u> | | | |

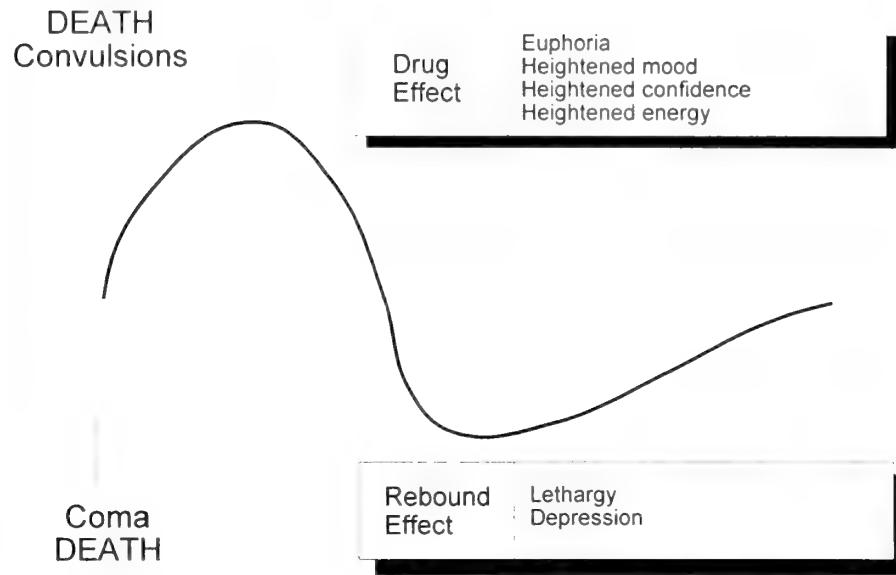
CNS Rebound Reaction Model



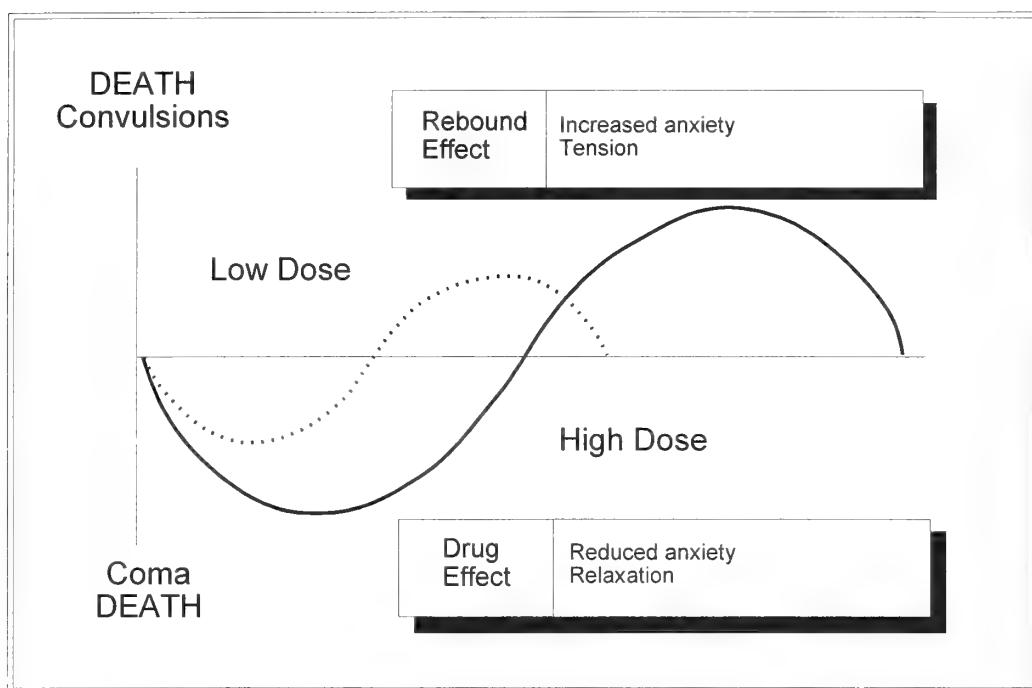
Rebound Reactions : CAFFEINE



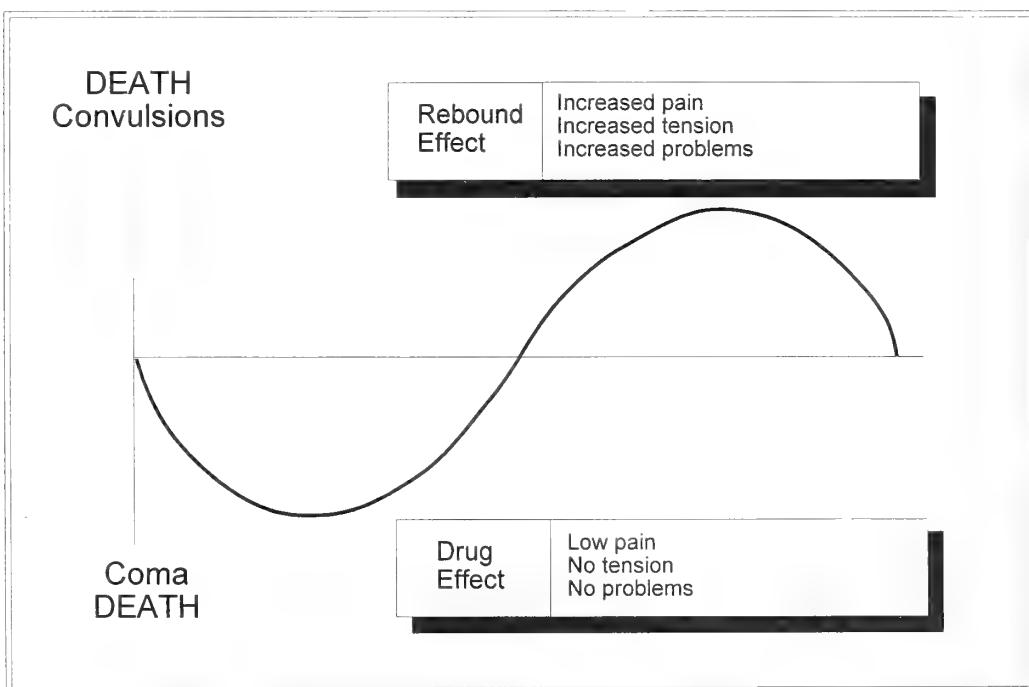
Rebound Reactions : COCAINE



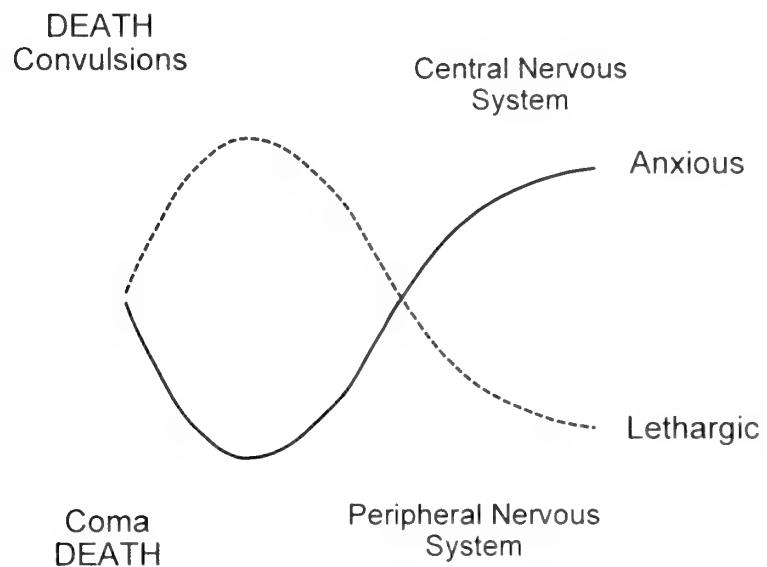
Rebound Reactions : ALCOHOL



Rebound Reactions : OPIATES



Rebound Reactions : NICOTINE



COCAINE COMPARISONS BY ROUTES OF INGESTION--1

| ROUTE | PURITY | ONSET | DURATION |
|-------------------------------------|--------|-------------|---------------|
| Intranasal "snorting" | 30% | 1-3 minutes | 20-40 minutes |
| Injecting | 40% | 6-8 seconds | 20-30 minutes |
| Inhalation "crack" "freebase" | 40-85% | 3-6 seconds | 3-12 minutes |

Smoking crack or freebasing gets the greatest quantity of the drug to the brain by the fastest route of administration, resulting in the greatest dependence-producing potential.

COCAINE CRISIS

Stem

metabolic crisis

discomfort

restless

energy

Cortex

toxic psychosis

paranoia

aggressive behavior

confidence / power

↑
dose/frequency
NT levels

As dose and frequency of use increase,
the cocaine user is at greater risk
of metabolic crisis or
toxic psychosis.

Unit 3

An Overview of Sexually Transmitted and Other Infectious Diseases

An Overview of Sexually Transmitted and Other Infectious Diseases

The incidence and prevalence of infectious diseases among AOD abusers, as well as among other high-risk individuals, have increased substantially in the last decade. Persons with AOD abuse problems are known to be susceptible to an array of infectious diseases, including human immunodeficiency virus (HIV) infection, sexually transmitted diseases (STDs), tuberculosis and hepatitis.

The risk for contracting infectious diseases is greater in individuals with AOD abuse problems than in non-AOD users for three major reasons:

- **They are more likely to be involved in drug-related activities, such as needle-sharing or trading sex (often unprotected) for drugs, that place them at risk.**
- **They may be more likely, because of sexual disinhibition associated with AOD use or having blackouts, to engage in sexual behaviors that place them at risk.**
- **The social networks of some AOD abusers may overlap with those individuals with STDs and TB.**

This section of the workshop has been designed to increase the knowledge of infectious diseases, primarily STDs and TB, for AOD treatment staff.

The Roles for AOD Treatment Providers in Infectious Disease Screening and Referral

The counselor in an AOD abuse treatment setting can play a key role in facilitating clients' assessment of their risks, providing HIV prevention counseling, assisting clients in developing a plan for risk reduction and retention in treatment strategies, and referring clients to medical, public health and other agencies.

The following services can be provided by AOD treatment staff that support the screening of clients for infectious diseases.

1. *Assess client risk factor.*

A complete history is needed if medical and AOD treatment staff are to adequately assess a client's risk for infectious disease. Information can be gathered prior to development of a treatment plan, during an intake interview or initial counseling sessions. Clients also need to personalize their risk behaviors. This can be done through one-on-one, prevention counseling sessions where clients can examine their behaviors and assess their risk for infectious disease.

2. *Provide prevention counseling.*

Counseling can be especially critical prior to and following STD, HIV and TB testing. Counselors should be aware of relapse possibilities when considering testing or waiting for results. It is critical that the counselor help prepare the client for the outcome of the test.

CDC Standards And Recommendations For "Giving Test Results"

- a. Assess client or patient readiness to receive test result. (Explore client or patient feelings about the test outcome.)
- b. Interpret result for client or patient, and ensure that she/he understands what the results mean. (Assist the client to begin to integrate emotionally, behaviorally and socially the test result.)
- c. Renegotiate or reinforce the existing plan for reducing risk, considering the client's or patient's HIV status.

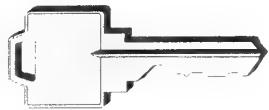
When giving test results make sure that a referral system is already in place and the patient or client has access to the system. Positive test results can be very traumatic and confusing. Negative test results can be an important opportunity to assist the client or patient in moving forward with behavioral changes. Counseling and referral assistance may be especially helpful for clients, patients and family members.

HIV Prevention Case Management Services Should Complement HIV Prevention Counseling

HIV Prevention Case Management:

3. ***Provide and follow up patient referrals.***
Clients infected with certain infectious diseases after the initial screening will require medical care. Counselors can arrange for health care if provided by the treatment program or can advocate in arranging for treatment as well as tracking follow-up care with the medical facility. Counselors should also encourage the client to take responsibility for maintaining their prescribed therapy.
4. ***Conduct and support risk reduction and treatment retention activities.***
Counselors can deliver or provide for the delivery of educational and awareness sessions focused on infectious diseases, counseling sessions and other support services that reduce the client's risk of contracting or transmitting infectious diseases.
5. ***Participate in staff development activities.***
Providing services to individuals using AOD continues to be challenging and rewarding work. Awareness training, skills development and supportive group activities can enhance abilities and improve services related to infectious diseases.

KEY FACTS



The Three R's of Sexually Transmitted Diseases

Risk increases with unprotected sex with different partners.

Risk can be reduced by limiting the number of partners.

Risk can be reduced by consistently and correctly using condoms during anal, vaginal or oral sex.

Many sexually transmitted diseases create a risk for very serious health problems. One's risk of getting an STD is far greater than getting HIV infection. STDs causing sores or lesions increase one's risk for additional infections, including HIV.

Recognition means knowing the signs and symptoms of sexually transmitted diseases (occurring generally from three days to three months following unprotected sex).

Recognize sores, rashes, inappropriate discharge, or other changes in your general health status.

Response

If an STD sign or symptom appears;

If an STD exposure is suspected (since some people don't experience the standard symptoms of STDs);

If a recent sex partner tells of having an STD; or

If a public health representative confidentially notifies you of an exposure to an STD.

Respond by protecting yourself during sex at once; avoid spreading infection; talk to recent partners; see your doctor or a clinic immediately; and, don't try self-treatment.

Sexually Transmitted Diseases: What AOD Programs Need to Know.

Sexually transmitted diseases are among the most common infectious diseases in the US today. More than 20 STDs have been identified, and they annually infect 13 million women and men in the US. Understanding the basic facts about STDs--characteristics, incidence, transmission modes, and treatment--will assist AOD treatment professionals and clients to openly and honestly discuss ways to prevent future infections or re-infections.

The National Institute of Allergy and Infectious Diseases (NIAID) has identified the following five key points to help us understand STDs.

1. STDs affect men and women of all backgrounds and economic levels. They are most prevalent among adolescents and young adults. Nearly two-thirds of all STDs occur in people younger than 25 years of age.
2. The incidence of STDs is rising, in part because during the last few decades young people have become sexually active earlier yet are marrying later. In addition, divorce is more common. The net result is that sexually active people today are more likely to have multiple sex partners during their lives and are potentially at risk for developing STDs.
3. Many STDs initially cause minimal or no symptoms, particularly in women. When symptoms develop, they may be confused with those of other diseases not transmitted through sexual contact. However, even when an STD causes no symptoms, a person who is infected may be able to pass the disease on to a sex partner. That is why many doctors recommend periodic testing for people who have more than one sex partner.
4. Health problems caused by STDs tend to be more severe and more frequent for women than for men, in part because the frequency of asymptomatic infection means that many women do not seek care until serious problems have developed.
 - Some STDs can spread into the uterus (womb) and fallopian tubes to cause pelvic inflammatory disease (PID), which in turn is a major cause of both infertility and ectopic (tubal) pregnancy. The latter can be fatal.
 - STDs in women may also be associated with cervical cancer. One STD, human papilloma virus infection (HPV), can result in genital warts, but can also lead to cervical and other genital cancers.
 - STDs can be passed from a mother to her baby before or during birth; some of these infections of the newborn can be cured easily, but others may cause a baby to be permanently disabled or die.
5. When diagnosed and treated early, almost all STDs can be treated effectively. Some organisms, such as certain forms of gonococci, have become resistant to the drugs used to treat them and now require newer types of antibiotics. The most serious STD for which no cure now exists is human immunodeficiency virus (HIV). Experts believe that having STDs other than HIV increases one's risk for becoming infected with HIV.

Gonorrhea

Gonorrhea is one of the most commonly identified STDs. Gonorrhea is caused by the gonococcus, a bacterium that grows and multiplies quickly in moist, warm areas of the body such as the cervix, urethra, mouth or rectum. In women, the cervix is the most common site of infection. However, the disease can spread to the uterus (womb) and fallopian tubes, resulting in pelvic inflammatory disease (PID) and scar tissue. The scar tissue resulting from PID may lead to fallopian tube blockage and infertility.

Gonorrhea is most commonly spread during genital contact, but it can also be passed from one partner to the throat of the other during oral sex (pharyngeal gonorrhea). Gonorrhea of the rectum can occur in people who practice anal intercourse and may also occur in women due to spread of the infection from the vaginal area.

Gonorrhea can be passed from an infected woman to her newborn infant during delivery. When the infection occurs in children, it is often determined to be due to sexual abuse.

Program Issues for Alcohol and Other Drug Treatment Settings

Testing - Testing is recommended for gonorrhea for those clients with indications of infection or for those who have had sexual contact with infected individuals. All persons with gonorrhea should be treated for presumptive chlamydia, have serologic screening for syphilis, and be offered confidential HIV Prevention Counseling.

Education and Counseling - Clients and patients should be provided with information about their infection including:

- source of spread;
- mode of transmission;
- incubation period; and,
- treatment.

Counselors should assist the patient in identifying risk factors and making a plan to prevent reinfection that has realistic solutions and incremental steps.

Medical Management of Pregnant Clients - Gonorrhea during pregnancy may cause spontaneous abortion, premature labor, early rupture of fetal membranes, and increased neonatal morbidity. A pregnant woman infected with gonorrhea risks infecting her infant during delivery. Therefore, all pregnant women should have an endocervical culture for gonorrhea during their first trimester and again late in the third trimester.

Infants born to infected mothers who have been properly treated rarely become infected. If the mother is not treated, the infection may cause conjunctivitis in infants. In a few cases, a more serious, systemic infection of the infant may occur.

Syphilis

Syphilis, once a cause of devastating epidemics, now can be effectively controlled with antibiotic therapy. Yet, in many US cities both adult and congenital syphilis are on the rise. Although treatment is available, the early symptoms of syphilis can be very mild, and many people do not seek treatment when they first become infected. Of increasing concern is the fact that a person with syphilis sores who has unprotected sex with someone who is infected with HIV is at high risk for contracting HIV infection.

Syphilis is caused by a bacterium called *Treponema pallidum*. The bacterium can move throughout the body, damaging many organs over time. Medical experts describe the course of the disease by dividing it into four stages: **primary, secondary, latent, and tertiary**. An infected person who does not get treatment may infect others during the first two stages and during the early latent stage, which usually lasts one to two years. In its late stages, untreated syphilis can cause serious heart abnormalities, mental disorders, blindness, other neurological problems, and death.

The bacterium spreads from the sores of an infected person to the mucous membranes of the genital area, the mouth, or the anus of a sexual partner. It can also pass through broken skin on other parts of the body. The syphilis bacterium is very fragile, and the infection is rarely, if ever, spread by contact with objects such as toilet seats or towels. A pregnant women with syphilis can pass the bacterium to her unborn child, who may be born with serious mental and physical problems as a result of this infection.

Program Issues for Alcohol and Other Drug Treatment Settings

The high correlation between substance abuse and syphilis makes it especially important to identify and treat the disease among clients and patients in AOD treatment settings. Syphilis, fortunately, is responsive to treatment with antibiotics. Risk assessment, screening (i.e. testing) and treatment should be accompanied by appropriate counseling and medical follow-up.

In setting up a screening and treatment or referral program, the following components need to be included:

- Risk assessment and screening should be provided for all persons entering AOD treatment programs. Syphilis is particularly prevalent among cocaine users, specifically those who smoke crack cocaine.
- Screening should be repeated every year if at-risk behavior continues, or earlier if signs and symptoms suggestive of syphilis infection occur.

Special Considerations with Infected Patients - Alcohol and other drug treatment programs need to be aware of the following issues with regard to patients infected with syphilis:

- Infected mothers should be advised to have their young children screened for undetected congenital syphilis if they were not screened at birth.

- Prevention counseling should be provided to persons known to be infected with syphilis. Counselors should assist clients in identifying risk factors and making a plan that is realistic and has incremental steps to prevent reinfection.
- Patients and clients in AOD treatment settings should be offered HIV prevention counseling. Syphilis may increase the risk for infection with and transmission of HIV.

Medical Management of Pregnant Clients - All pregnant women should be screened for syphilis during their initial prenatal care. If no prenatal care is provided, the woman should have serologic screening for syphilis at the time of delivery. In populations at high risk for syphilis, the screening should be done at the initial prenatal visit, at the end of the second trimester, and at the time of delivery.

Chlamydia

Chlamydial infection is the leading sexually transmitted disease in the Nation today. Pelvic inflammatory disease, a serious complication of chlamydial infection, has emerged as a major cause of infertility among women of childbearing age. Chlamydial infection is caused by a bacterium, *chlamydia trachomatis*, and is transmitted during vaginal or anal sexual contact with an infected partner. A pregnant woman may pass the infection to her newborn during delivery, with subsequent neonatal eye infection or pneumonia.

Chlamydia causes a diverse group of genital and neonatal infections including many that were previously considered of unknown cause. Chlamydia are unique microorganisms, whose specific properties have been delineated extensively only in the last two decades. Although classified as bacteria, they share properties with viruses **and** bacteria. They possess cell walls and membranes analogous in structure to the cell walls of bacteria. Like viruses, chlamydia grow only intracellularly. Unlike viruses, however, chlamydia contain both DNA and RNA and divide by binary fission.

Women may develop pelvic inflammatory disease (PID), an infection of the reproductive organs that is usually accompanied by pain in the lower abdomen and fever. Up to one half of PID cases result from chlamydial infection. Gonorrhea is the other leading cause of PID. PID also causes an estimated 100,000 women a year to become infertile.

An even more serious potential complication of PID is ectopic pregnancy, which occurs when a fertilized egg is implanted and grows in the fallopian tube. The growing embryo may cause the tube to rupture. Because of the resulting internal bleeding, a ruptured ectopic pregnancy is a life-threatening emergency to the woman.

Men infected with chlamydia can develop nongonococcal urethritis (NGU), an inflammation of the urinary tract that is characterized by a penile discharge and sometimes by pain during urination. Chlamydia causes approximately 40 percent of the cases of NGU.

Chlamydia in men can also cause epididymitis, an inflammation of the epididymis, a part of the male reproductive system in the testicles. Epididymis can cause sterility in men if not treated.

Program Issues for Alcohol and Drug Treatment Settings

Screening - Screening for chlamydial infection is strongly encouraged, particularly for high-risk pregnant women, adolescents and clients with multiple sexual partners.

Education and Counseling - Clients should be provided information about their infection including:

- source of spread;
- transmission;
- incubation period; and,
- treatment.

Counselors should assist the patient or client in identifying risk and making a plan to prevent reinfection that has realistic solutions and incremental steps.

Medical Management of Pregnant Clients - Chlamydia can be passed from an infected mother to an infant during delivery and may lead to conjunctivitis or pneumonia in the newborn. For this reason, routine testing of all pregnant women for chlamydia is recommended.

Appropriate screening should be done at the first prenatal visit and during the third trimester. Women with untreated chlamydia at delivery may develop postpartum endometritis after vaginal delivery and require treatment.

Chlamydia during pregnancy may cause spontaneous abortion, premature labor, early rupture of fetal membranes, and increased neonatal morbidity.

Genital Herpes

Genital herpes is a contagious viral infection that affects an estimated 30 million people living in the U.S. Each year, as many as 500,000 new cases are believed to occur. The infection is caused by the herpes simplex virus (HSV). There are two types of HSV, and both can cause the symptoms of genital herpes. HSV type 1 most commonly causes sores on the lips (known as fever blisters or cold sores), but it can cause genital infections as well. HSV type 2 most often causes genital sores, but it can also infect the mouth.

HSV 1 and 2 can both produce sores in and around the vaginal area, on the penis, around the anal opening, and on the buttocks or thighs. Occasionally, sores also appear on other parts of the body where broken skin has come into contact with HSV. The virus remains in certain nerve cells of the body for life, causing periodic symptoms in some people.

Genital herpes infection is usually acquired by sexual contact with someone who has an outbreak of herpes sores in the genital area. People with oral herpes can transmit the infection to the genital area of a partner during oral-genital sex. Herpes infections can be transmitted by a person who is infected with HSV but has no noticeable symptoms.

Program Issues for Alcohol and Other Drug Treatment Settings

Testing - for herpes is recommended for clients with genital, rectal or oral ulcers.

Education and Counseling - Clients should be provided with information about their infection including:

- source of spread;
- mode of transmission;
- incubation period;
- treatment; and,
- signs and symptoms.

Counselors should assist clients and patients in making a plan that would decrease the risk of transmission of HSV. HIV Prevention Counseling should be offered to all people infected with genital HSV.

The risk of neonatal infection should be explained to all patients--male and female--with genital herpes. Women of childbearing age should be advised to inform their physician of any history of infection if they become pregnant.

Medical Management of Pregnant Clients - Most neonates who are infected with herpes simplex virus at the time of passage through the birth canal are born to mothers with no history of clinically apparent genital herpes.

At the onset of labor, all women should be carefully examined for the presence of active lesions. If the woman has signs or symptoms suggestive of active genital herpes, the baby should be delivered by Caesarean section.

Human Papillomavirus and Genital Warts

Human papillomavirus (HPV) is one of the most common causes of sexually transmitted disease in the US. It is estimated that as many as 40 million Americans are infected with HPV, and the incidence of this disease appears to be on the increase. More than 60 types of HPV have been identified by scientists. Some types of the virus cause common skin warts. About one-third of the HPV types can be spread through sexual contact. Several types of HPV can lead to genital warts, the most recognizable sign of genital HPV infection. Certain other types of HPV have been closely associated with the development of cervical cancer and other genital cancers.

Like many STDs, HPV infection often does not cause visible symptoms. One study sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) reported that almost half of the women infected with HPV had no obvious symptoms. Because the virus can remain latent in the skin, infected persons may not be aware of their infection and the potential risk of complications.

There are no screening tests for HPV. Diagnosis of genital warts is made by recognizing the lesions. Regular Pap smears can detect cellular changes in the cervix that are due to HPV infection. It may take many years for the cellular changes to occur. Appropriate treatment can be given to prevent the cellular changes from progressing to cancer.

Viral Hepatitis - What AOD Programs Need To Know.

The term **viral hepatitis** is commonly used for several similar diseases that are caused by different viruses and affect different groups of people. The viruses include hepatitis A virus (HAV), hepatitis B virus (HBV), and parenterally transmitted (or blood borne) non-A, non-B hepatitis most of which is caused by the hepatitis C virus (HCV). Hepatitis A was once known as infectious, or short-incubating hepatitis; hepatitis B was known as serum, or long-incubating hepatitis. Parenterally transmitted non-A, non-B hepatitis is now commonly referred to as hepatitis C.

HAV infection is not commonly sexually transmitted. HCV infection has been known to be transmitted sexually, but the magnitude of this risk is unknown at this time. HBV infection can be a sexually transmitted disease. In 1990, 20 percent of persons with HBV infection reported that their primary risk factor for infection was having more than one heterosexual partner in the six months prior to onset of illness; 11 percent of persons reported homosexual activity as their only risk factor for disease.

As a human carcinogen, HBV is second only to tobacco. Liver cancer caused by chronic HBV infection is the number one killer of males living in hyperendemic areas of the world.

Course of Infection

Patients with hepatitis may have symptoms such as fever, anorexia, nausea, myalgia, malaise, dark urine and yellowing of the skin and eyes (jaundice). Many infections are asymptomatic, mild and without jaundice. Adults tend to be symptomatic more often than young children. Liver enlargement can produce pain in the right upper quadrant of the abdomen, and the enlarged liver may be felt upon examination. Most patients with hepatitis recover and return to normal. In a few patients, the disease rapidly progresses to fulminant hepatitis; those patients die of liver failure.

Patients with HBV infection may develop chronic hepatitis (five to 10 percent). The prolonged inflammation can result in replacement of the liver cells by scarring (cirrhosis). Liver function may gradually deteriorate, and the patient may succumb to liver failure and death. Persons with chronic HBV infection may also develop hepatocellular carcinoma (primary liver cancer). There are no chronic manifestations for HAV infection. About 50 percent of patients with acute HCV infection will remain chronically infected with the associated risk of chronic hepatitis and cirrhosis.

Program Issues for Alcohol and Other Drug Treatment Settings

Alcohol and other drug treatment programs should routinely screen for hepatitis B. All persons known to have used injection drugs should be tested for hepatitis C. Liver enzymes should also be measured. Additional testing needs to be done as follows:

- Serologic testing for hepatitis A should be done only in persons with acute hepatitis.
- Serologic testing for hepatitis C virus should be done only in persons with known hepatitis B virus infection who have chronic hepatitis and are hepatitis B surface antigen (HBsAg) positive, since the presence of serologic evidence of infection with hepatitis C does not alter the clinical follow-up or therapeutic intervention from that of a client with chronic HBV infection.

Hepatitis B - The prevalence of HBV infection among injection drug users in the US ranges from 60 to 80 percent, depending on the region. Because of this high prevalence, all persons enrolled in an alcohol or other drug treatment program and all clinical staff should be screened for prior HBV infection.

Screening for HBV infection is mandatory in methadone treatment programs and should be accompanied by appropriate counseling, vaccination, and needed medical follow-up. Screening for HBV in these high-risk groups has been shown to be cost-effective.

Medical Management Issues of Pregnant Clients - A woman who has active hepatitis should be advised not to become pregnant.

All pregnant clients should be tested for HBsAG early in pregnancy. If the woman is at high risk for HBV infection, the HBsAg test should be repeated late in pregnancy even if the woman was initially HBsAg negative.

The risk of perinatal transmission from an HBV-infected mother to her infant ranges from 10 to 85 percent, according to various studies. Pregnant clients with known risk behavior should be vaccinated, since hepatitis B vaccine may be given safely to pregnant and lactating or breast feeding women. If the pregnant woman is HBsAg positive, screening and vaccinating of her at-risk household contacts as well as her drug and sexual partners should occur.

Tuberculosis - What AOD Programs Need To Know.

An update on tuberculosis for AOD treatment staff is critical today. After a decades-long decrease in the number of TB cases reported in the United States, TB has reemerged as a serious national problem. From 1985 through 1993, the number of new TB cases increased by 14 percent. This increase can be attributed to at least four factors:

- The association of TB with the HIV epidemic
- Immigration from countries where TB is common
- The transmission of TB in congregate settings (e.g., health care facilities, residential AOD treatment programs, correctional facilities)
- A deterioration of the health care infrastructure.

Moreover, the recent occurrence of several outbreaks of multidrug-resistant TB has pointed to the need for new treatment regimens. New methods of diagnosis have been introduced, and guidelines for patient management and public health practice have been revised. However, 25 percent of patients who start treatment do not complete a recommended regimen within 12 months.

In 1995, a total of 22,813 cases of TB (8.7 cases per 100,000 population) were reported to CDC--a 6.4 percent decrease from 1994 (24,361 cases [9.4 cases per 100,000]). This represented the third consecutive year the number of reported TB cases had decreased.

Preliminary analyses of national surveillance data and TB-control program management reports indicate that the decrease in cases in US-born persons largely reflected improvement in program performance.

Transmission and Pathogenesis

TB is an airborne communicable disease caused by *Mycobacterium tuberculosis*, or the tubercle bacillus. It is spread by tiny airborne particles (droplet nuclei) expelled by a person who has infectious TB. If another person inhales air containing these droplet nuclei, transmission may occur. The immune system response usually prevents the development of active TB disease. Persons who are infected but who do not have TB disease are asymptomatic and not infectious; such persons usually have a positive reaction to the tuberculin test. About 10 percent of infected persons will develop TB disease at some time in their lives, but the risk is considerably higher for persons who are immunosuppressed, especially those with HIV infection. Although the majority of TB cases are pulmonary, TB can occur in almost any anatomical site or as disseminated disease.

The best way to stop transmission is to isolate patients with infectious TB immediately and to start effective TB therapy. Infectiousness declines very rapidly after adequate therapy is started, as long as the person adheres to the prescribed regimen.

Persons at the highest risk of becoming infected with *M. tuberculosis* are close contacts—persons who often spend time with someone who has infectious TB. Close contacts may be family members, roommates, friends, coworkers, or others. These persons are at risk for TB infection because they are more likely to be exposed to TB.

TB infection progresses to disease when tubercle bacilli overcome the defenses of the immune system and begin to multiply. Infection can progress to disease very quickly or many years after infection. In the US, in approximately 5 percent of persons who have been recently infected with *M. Tuberculosis*, TB disease will develop in the first year or two after infection. In another 5 percent, disease will develop later in their lives. In other words, in approximately 10 percent of infected persons, TB disease will develop at some point. The remaining 90% will stay infected, but free of disease, for the rest of their lives.

Conditions That Increase the Risk of TB Disease

Some medical conditions increase the risk that TB infection will progress to disease. The risk may be approximately three times greater (as with diabetes) to more than 100 times greater (as with HIV infection) for persons who have these conditions than for those who do not. Some of these conditions include:

- HIV infection
- Substance abuse (especially drug injection)
- Recent infection with *M. tuberculosis* (within the past two years)
- Chest x-ray findings suggestive of previous TB (in a person who received inadequate or no treatment)
- Prolonged corticosteroid therapy
- Other immunosuppressive therapies
- Low body weight (10 percent or more below the ideal).

Studies suggest that the risk of developing TB disease is 7 to 10 percent each year for persons who are infected with both *M. tuberculosis* and HIV, whereas it is 10 percent over a lifetime for persons infected only with *M. tuberculosis*.

Screening for TB Disease and Infection

In most US populations, screening for TB is done to identify infected persons at high risk for TB disease who would benefit from preventive therapy and to identify persons with TB disease who need treatment. All screening activities should be accompanied by a plan for follow-up care for persons with TB infection or disease.

The preferred method of screening for TB infection is the Mantoux tuberculin skin test. High-risk groups that should be screened for infection include:

- persons with HIV infection or risk factors for HIV but unknown HIV status
- close contacts of a person with infectious TB
- persons who inject drugs
- medically under served, low income populations
- residents of long-term care facilities.

Persons with HIV disease may test negative to the Mantoux test. The absence of a reaction to the tuberculin test does not rule out the diagnosis of TB disease or infection. In immunosuppressed persons, delayed-type hypersensitivity responses such as tuberculin reactions may decrease or disappear. This condition, known as anergy, may be caused by many factors. On average, 10 to 25 percent of patients with TB disease have negative reactions when tested with a tuberculin skin test. Approximately one third of patients with HIV infection and more than 60 percent of patients with AIDS may have skin reactions of <5mm even though they are infected with *M. tuberculosis*.

Anergy can be detected by administering at least two other delayed-type hypersensitivity antigens, such as tetanus toxoid, mumps, or *Candida*, by the Mantoux technique. If anergy is demonstrated, the probability of infection should be assessed, and persons whose risk of exposure is judged to be high (known contacts of persons with infectious TB or persons from a group with a high prevalence of TB infection) should be evaluated for preventive therapy.

Diagnosis of TB

The symptoms of pulmonary TB include a productive and prolonged cough, chest pain, and hemoptysis; the specific symptoms of extra pulmonary TB depend on the site of the disease. Systemic symptoms consistent with TB also include fever, chills, night sweats, easy fatigability, loss of appetite, and weight loss. TB should be considered in persons who have these symptoms. Persons suspected of having TB should be referred for a complete medical evaluation, which should include a medical history, a physical examination, a Mantoux tuberculin skin test, a chest x-ray, and any appropriate bacteriologic or histologic examinations.

A positive bacteriologic culture for *M. tuberculosis* confirms the diagnosis of TB. However, if TB disease is not ruled out, treatment should be initiated; clinicians should not wait for bacteriologic results before starting therapy.

A complete medical evaluation for TB should include a medical history, a physical examination, a Mantoux tuberculin skin test, a chest x-ray, and any appropriate bacteriologic culture results before starting therapy.

Program Issues for Alcohol and Drug Treatment Settings

Alcohol and other drug treatment programs funded under the **Substance Abuse Prevention and Treatment Block Grant** are now required by statute and regulation to provide tuberculosis services to patients/clients or to ensure that patients/clients receive such services. Section 1924(a) of the ADAMHA Reorganization Act of 1992 (P.L. 102-321) states that:

States must require treatment entities receiving funds under grant to make available tuberculosis services to each individual receiving treatment; in the case of an individual denied admission due to lack of capacity, the treatment entity will refer the individual to another provider of tuberculosis services (defined as counseling, testing, or treatment).

Transmission of tuberculosis is most effectively reduced by identifying and treating persons with active pulmonary TB disease. A full course of preventive therapy can reduce the risk of developing active TB in infected persons by more than 90 percent.

Because patients receiving methadone come to treatment centers frequently--often on a daily basis--for extended time periods, methadone treatment programs are in a unique position to provide daily or twice weekly preventive therapy for the recommended six- to 12-month period. This preventive service can usually be provided in collaboration with the public health agency.

Special Considerations with Infected Patients - Persons with close contact to a person with untreated tuberculosis of the lungs or larynx are at greatest risk of acquiring infection.

The treating physician should inform the case manager in the AOD treatment program about patients who are being treated for active TB. If a patient is infectious, medical staff should ensure that isolation is initiated and that appropriate precautions to protect staff and other clients are enforced until the patient becomes noninfectious. The need to monitor drug adherence and to determine drug efficacy and potential drug toxicity all highlight the importance of monitoring. For short-term treatment programs, treatment needs to be supervised and aftercare should be provided, including follow-up with a specific provider and case manager.

Medications for TB preventive therapy and treatment may interact with other drugs, such as methadone, disulfiram (Antabuse), and protease inhibitors (saquinavir, ritonavir, indinavir) thus requiring careful monitoring and possible dosage adjustment. **Rifampin** (RIF) may interact with either methadone or disulfiram and may require an increase in methadone dosage. Isoniazid (INH) must be given with care to patients on disulfiram, since such patients can have psychotic episodes or ataxia (muscular incoordination).

Protease inhibitors are contraindicated for concurrent administration with Rifampin. A specialist should be consulted for personalized treatment of both HIV and TB concurrently.

Considerations for Drug Treatment Staff - All health care personnel should have PPD skin tests every six to 12 months, and at the time of and three months after any exposure to an individual in treatment with active, untreated TB. The following testing should be done:

- In general, all staff of AOD treatment programs should receive a PPD skin test using the Mantoux method when they are first employed.
- Staff with initial negative skin tests should be retested every six to 12 months.
- Staff with positive skin tests should receive a prompt medical evaluation for possible active TB, should be considered for TB preventive therapy, and should be evaluated if symptoms of active TB develop.

Special Considerations for Methadone Recipients and Pregnant Women

Methadone Recipients - Drugs for prophylaxis or treatment of tuberculosis should be given with methadone whenever possible. Persons on methadone maintenance and rifampin may require an increased methadone dose if the person has signs and symptoms of drug withdrawal.

Pregnant Women - TB skin testing and anergy testing are safe during pregnancy. Pregnant women with active tuberculosis or who are suspected of having active TB should be referred to a specialist. Treatment should not be delayed.

An HIV-positive pregnant woman with a positive TB skin test and no clinical evidence of active TB disease should receive INH prophylaxis for 12 months. An HIV-positive pregnant woman at risk for TB who is anergic and has no clinical evidence of active TB should receive INH prophylaxis for 12 months. The prophylaxis should be initiated at the end of the first trimester of pregnancy.

An HIV-positive pregnant woman who has recently been exposed to a person with infectious TB should be given INH prophylaxis regardless of the stage of pregnancy. An HIV-negative pregnant woman who has recently been exposed to a person with infectious TB and has a positive skin test should be given INH prophylaxis during pregnancy. The drug, however, should not be initiated until the end of the first trimester.

Any pregnant woman with radiographic evidence of possible past TB that was never treated should be given one year of INH prophylaxis. Treatment should begin during pregnancy, but not until the end of the first trimester. For other pregnant women who have positive skin tests, INH preventive therapy should be delayed until after the pregnancy.

Multidrug-Resistant Tuberculosis

The emergence of multidrug resistant tuberculosis (MDR-TB) as a major health problem over the past several years has prompted the Centers for Disease Control and Prevention (CDC) to closely reexamine tuberculosis policy in the US. A series of guidelines have been issued by the CDC since 1991 concerning MDR-TB in the US. The following statement is extracted from CDC's "National Action Plan to Combat Multidrug-Resistant Tuberculosis" (p.7).

Recently, drug-resistant TB has become a serious concern. In a recent survey in New York, 33 percent of cases had organisms resistant to at least one drug, and 19 percent had organisms resistant to both isoniazid (INH) and rifampin (RIF), the two most effective drugs available for treating TB. When organisms are resistant to both INH and RIF, the course of treatment increases from six months to 18-24 months, and the cure rate decreases from nearly 100 percent to less than 60 percent.

Unit 4

Promoting Risk Assessment and Harm Reduction

Promoting Risk Assessment and Harm Reduction: Behavior Change Model

How do people intentionally change behaviors? Behavioral science tells us that not all clients or patients can successfully change behaviors. Some drop out of substance abuse treatment, others relapse with unsafe sexual behaviors or drug and alcohol abuse following some attempts at behavior change.

Prior to an examination of screening approaches, risk assessment strategies and harm reduction techniques, this unit will provide common principles that can reveal the structure of change.

Whether counseling an active or relapsing substance abuser or providing treatment to a person with a sexually transmitted or infectious disease, it is important that we support self-directed behavior change. This allows counselors to:

- work with the individual wherever she/he may fall along the spectrum of drug use, abuse, addiction or recovery;
- work with the ambivalence felt by a client/patient who is attempting to change risky sexual behaviors;
- work cooperatively with the individual to set her/his own priorities and time lines for action; and,
- develop effective AOD or sexual behavior related interventions appropriate for the clients' readiness for change.

Many traditional harm-reduction/behavior change strategies have focused on the provision of information or materials related to AOD and safer sex practices. We quite often design excellent "action-oriented" treatment and self-help programs but then are disappointed when only a small number of people register or attend.

On the next page a *behavior change model*, as described in the CDC HIV PREVENTION COUNSELING curriculum, provides a useful framework for patients and clients attempting to modify behaviors. This model highlights the fact that everyone falls somewhere in a continuum of a behavior change cycle.

CDC Behavioral Change Model

1. Knowledge and Awareness

A client or patient must be aware of the consequences of behavior before a change will occur. Knowledge must be present for a patient to make a behavior change. However, knowledge alone is not a motivator to change behavior. Clients may know how HIV is transmitted; may know how to protect themselves from risky behaviors; may know about the effects of addiction. Yet they may be unwilling to change behaviors.

2. Significance to Self

Clients must identify with a particular event consequence. Significance of self to self will affect how behavior change may occur. Measuring denial, fatalism and self-efficacy can indicate how much control a client or patient may feel about ability to change behavior.

3. Cost Benefit Analysis

Clients will need to measure losses and gains of changing behaviors, including the impact of change on significant others. Counselors should help clients examine costs and benefits of current behavior and behavior change. Clients may get stuck and need help to resolve those competing needs and values.

4. Capacity Building

When clients and patients know the risks of certain behaviors and realize the consequence of the behavior, they may be faced with a lack of skills to carry out the new behaviors. Clients should identify skills that are specific, practical, and achievable. New skills should not be directives from the counselor on how to act.

5. Provisional Try

Clients and patients should agree to implement steps toward changing behavior.

Simple Screening Instruments

The development of the two screening instruments for assessment of AOD abuse and infectious disease was motivated by the **Center for Substance Abuse Treatment's** (CSAT's) recognition that simple instruments are needed to screen for these two conditions that occur together with high prevalence in some populations. Workers in each of these fields need to be knowledgeable about how to screen their clients for the disorders and problems of the other.

AOD abuse treatment personnel need to be able to identify risk factors for infectious diseases in the individuals in their programs. Similarly, disease intervention specialists working with persons being treated for infectious diseases need to be alerted to signs of possible AOD abuse which influence risky sexual practices.

The screening instruments presented in this document were designed for use by AOD and disease intervention specialists to screen for disorders with which they may have limited familiarity. The AOD instrument is intended for use primarily by infectious disease personnel, whereas the infectious disease screening instrument is designed for use primarily by AOD workers. The use of these instruments in this manner can enhance the detection of these often co-morbid conditions and can promote communication between referral agencies to foster the development of a network of treatment programs and other resources for clients.

Rationale for Concomitant Screening

Many, if not most, of the factors that place an individual at high risk for either substance abuse disorders or infectious diseases also place them at risk for the other of these two problems. For instance, injecting drug users, in addition to being highly likely to have an addiction problem, are also at high risk for infection with HIV because of the practice of works-sharing that is common in many communities. Similarly, an individual with STDs may also be likely to have an alcohol or other drug abuse problem, owing to the sexual disinhibition that is often produced by AOD abuse or the selling of sex for drugs which may have led to high-risk sexual encounters.

Ultimately, it is hoped that screening for both AOD abuse and infectious diseases concomitantly will facilitate access to health care for at-risk individuals by promoting early identification of these problems. In addition, the appropriateness and specificity of treatment placement can be improved when a co-morbid client is accurately screened. For example, individuals with infectious diseases can receive appropriate intervention, such as preventive therapy for potential latent TB infection in HIV-infected clients, in the AOD treatment program. Another alternative would be to refer these individuals for appropriate treatment of the infectious condition. The risk of illness and spread of disease to the community could thus be reduced.

One of the basic tenets of understanding the process of screening is the recognition that its goal is not to diagnose a specific problem, but to determine whether an individual needs further, more comprehensive, assessment and evaluation. Several aspects of the screening process should therefore be clarified before you administer the screening instruments for AOD abuse and infectious diseases:

- Although the screening process is often used to identify individuals at risk for a diagnosis, it is never diagnostic in and of itself.
- An individual with a positive screening test must have a clinical assessment before a diagnosis can be made and before clinical management can begin.
- Screening instruments are often intentionally designed to achieve high sensitivity--to identify large numbers of persons with the disease or condition. Therefore, screening tests may have a low positive predictive value; in other words many individuals with a positive screening test will subsequently be found not to have the disorder. Conversely, a negative screening test may not necessarily rule out the possibility that the disorder is present.
- Screening instruments may not assist an individual to develop less risky behaviors. While screening information can be collected and discussed, the person may not really personalize her/his risk for contracting an infectious disease or progressing on to more serious AOD abuse.

In Unit One, we discussed the magnitude of AOD abuse and infectious disease problems in the populations with which workers come into contact. To review, AOD abuse and infectious diseases are enormous public health problems. Although each of these problems alone has broad public health implications and incurs significant costs, the impact of both together on the acquisition and transmission of HIV has increased their individual importance even further.

Furthermore, the two problems overlap. TB and STDs, for example, are highly prevalent in populations in which AOD abuse is common. Conversely, it has been estimated that as many as 30 percent of patients admitted to general hospitals have some type of AOD abuse problem (Moore et al., JAMA 261:403-4-7, 1989). AOD abuse is associated with behaviors (such as high-risk sexual behavior and works-sharing practices) that increase the risk for STDs and HIV. It is also linked to crowded living situations (such as those in homeless shelters and correctional settings where crowding makes transmission more likely) that increase the risk for acquiring TB.

Screening can play an important role in containing these two problems if employed as a first step toward assessment and treatment. The question arises, however, about the usefulness of screening instruments if they identify clients who need services that are not available because of an already overtaxed treatment system. It is hoped that the use of the instruments will, at the least, serve a valuable information-gathering function that will indicate needs and eventually lead to more funding for treatment resources.

Potential Barriers to Using Screening Instruments

Despite the important reasons to screen for AOD problems and infectious diseases, potential barriers exist that may make service providers apprehensive about the screening process. Take a few moments and list barriers you may encounter.

Education about the relationship between AOD abuse and infectious diseases is key to overcoming such misconceptions and apprehensions on the part of staff. Workers using these instruments need to understand AOD abuse and infectious diseases as two interrelated problems that must be approached together for interventions to be effective.

Skills for Administration of the Screening Instruments

As with any screening process that takes the form of an interview, administration of the instruments presented here requires the specialized skills on the part of the interviewer in order to establish rapport with the client. List the skills you think are needed to effectively use the screening instruments.

Self-Comfort Inventory

To employ the skills needed for utilizing the screening instruments, we should feel comfortable. This is especially true because of the highly personal and intimate nature of many of the questions, such as those dealing with sexual behavior or current AOD use. It may help to anticipate such situations, explore our potential reactions to them, and plan how to manage or develop our sensitivities where appropriate.

On the next page is a series of situations that can occur when administering the screening instruments. Read each situation, and circle the number to the right that most closely reflects your feelings at the thought of being involved in the situation.

| | | | | |
|-------------------------------------|------------------------------------|----------------------------|----------------------------------|-----------------------------------|
| 1 extremely uncomfortable | 2 somewhat uncomfortable | 3 mixed feelings | 4 somewhat comfortable | 5 extremely comfortable |
|-------------------------------------|------------------------------------|----------------------------|----------------------------------|-----------------------------------|

1 2 3 4 5

1. Questioning a client or patient about continued alcohol or drug abuse.

1 2 3 4 5

2. Discussing with a pregnant patient or client their alcohol or drug use and sexual activities.

1 2 3 4 5

3. Displaying safer sex materials in your office.

1 2 3 4 5

4. Explaining to a patient or client how a female condom works.

1 2 3 4 5

5. Answering a question from a client about your use of condoms or dental dams.

1 2 3 4 5

6. Explaining the meanings of a positive or negative HIV antibody test to a client or patient with HIV symptoms who doesn't want to be tested.

1 2 3 4 5

7. Asking about how an individual's alcohol or other drug use is connected to their self-reported high number of sexual partners.

1 2 3 4 5

8. Counseling a client with TB symptoms who refuses to be tested.

1 2 3 4 5

9. Hearing that a client refuses to tell her partners that she has syphilis.

1 2 3 4 5

10. Hearing that a client is vowing revenge on persons who infected him with HIV disease.

1 2 3 4 5

11. Discussing safer sex techniques with a woman whose sexual partner is a crack user and physically abusive.

1 2 3 4 5

12. Conducting a sexual history with a client of the opposite sex and asking about their anal sex practices.

1 2 3 4 5

13. Inquiring about safer sex behaviors with a lesbian woman or gay man.

1 2 3 4 5

14. Asking questions about an individual's positive HIV test when you think she is high.

Managing and Developing Our Sensitivities

As the previous inventory has probably indicated, our attitudes, feelings and values vary by circumstance. While neither "right" nor "wrong", our sensitivities, feelings and values tend to influence our behavior, including counseling.

One way of developing personal attitudes more supportive of effective interviewing is to identify those feelings that are causing us "discomfort" and to use familiar ways to translate such discomfort into positive strengths or at least comfort levels.

Review your inventory, and in the space below, list:

- one of the situations scored "moderately" or "extremely uncomfortable", and
- one situation scored "moderately" or "completely comfortable".

Can you identify the specific feeling(s) that you associate with each? Try to identify the source (a value, belief, or attitude that may stimulate the feeling) in each situation.

| Situation # | Associated Feeling(s) | Source |
|-------------|-----------------------|--------|
| | | |

Considering the discussions of personal assessments list below some potential strategies to develop comfort when requesting sensitive information:

Simple Screening Instrument: Alcohol and Other Drug Abuse

(for use by Disease Intervention Specialists)

Interview Form

Note: **Boldfaced questions** constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I am going to ask you a few questions about your use of alcohol and other drugs during the past six months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary--it would be your choice whether to have an additional assessment or not."

During the past six months...

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.) (yes / no)**
2. **Have you felt that you use too much alcohol or other drugs? (yes / no)**
3. **Have you tried to cut down or quit drinking or using drugs? (yes / no)**
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program.) (yes / no)
5. Have you had any of the following?
 - blackouts or other periods of memory loss
 - injury to your head after drinking or using drugs
 - convulsions, seizures or delirium tremens ("DTs")
 - hepatitis or other liver problems
 - feeling sick, shaky, or depressed when you stopped drinking or using drugs
 - feeling "coke bugs", or a crawling feeling under the skin, after you stopped using drugs
 - injury after drinking or using drugs
 - Have you ever used needles to shoot drugs?
6. Has drinking or other drug use caused problems between you and your family or friends? (yes / no)
7. Has your drinking or other drug use caused problems at school or work? (yes / no)

8. Have you ever been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes / no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes / no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes / no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes / no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes / no)
13. Do you feel bad or guilty about your drinking or drug use? (yes / no)

"Now I have some questions that are not limited to the past six months."

14. Have you ever had a drinking or drug problem? (yes / no)
15. Have any of your family members ever had a drinking or drug problem? (yes / no)
16. **Do you feel that you have a drinking or drug problem now?** (yes / no)
 - Thanks for answering these questions.
 - Do you have any questions for me?
 - Is there something I can do to help you?

Notes:

Observation Checklist

The following signs and symptoms *may* indicate an AOD abuse problem in the individual being screened:

- needle track marks
- skin abscesses, cigarette burns, or nicotine stains
- tremors (shaking and twitching of hands and eyelids)
- unclear speech: slurred, incoherent, or too rapid
- unsteady gait: staggering, off balance
- dilated (enlarged) or constricted (pinpoint) pupils
- scratching
- swollen hands or feet
- smell of alcohol or marijuana on breath
- drug paraphernalia such as pipes, rolling paper, syringes, or roach clips
- "nodding out" (dozing or falling asleep)
- agitation
- inability to focus
- burns on the inside of the lips (from freebasing cocaine)

Notes on the AOD Screening Questions

The screening instrument begins with a question about the individual's consumption of alcohol and other drugs (Question 1). This question is intended to help the interviewer decide whether to continue the interview--if the response to this first question is no, continued questioning may be unnecessary.

Questions 2-4 are problem recognition items intended to elicit an individual's assessment of whether too much AODs are being used, whether attempts have been made to stop or control AOD use, and whether previous treatment has been sought. Answers to these questions may help the service provider understand how the individual thinks and feels about her or his use of AODs. People who later report negative consequences as the result of their AOD use but who nevertheless answer "no" to these problem recognition questions may have poor insight about their AOD abuse or may be denying the severity of their AOD problem.

Questions 5-12 were designed to determine whether an individual has experienced any adverse consequences of AOD abuse. These include medical, psychological, social, and legal problems that are often caused by AOD abuse and addiction. Some questions are intended to elicit symptoms of aggression (Question 9), physical tolerance (Question 10), preoccupation (Question 11), and loss of control (Question 12). Question 13 is designed to tap feelings of guilt, which may indicate that the individual has some awareness or recognition of an AOD problem. Questions 14 and 16 are intended to measure the respondent's awareness of a past or present problem. Question 15 elicits the individual's family history of AOD problems.

Parenthetical words or phrases that accompany some of the screening questions are intended to provide the interviewer with specific examples of what is being looked for or to help the respondent understand the question. For instance, Question 1 asks whether an individual has used AOD, and the wording in parentheses prompts the interviewer to ask about specific substances of abuse.

Simple Screening Instrument: Infectious Diseases

(for AOD staff)

Interview Form

Suggested Introductory Statement

"A lot of people who use alcohol and other drugs have health problems that they don't even know they have. I want to find out whether you might have any health problems that we can help you with.

Even if you don't feel sick, there could still be something going on with your health that we can do something about before it turns into a bigger problem. To find out, I need to ask you some questions in order to get some information from you.

Based on your answers to these questions, we may advise you to get a physical exam. This would be voluntary--it would be your choice whether to have the exam or not. If you do get an exam, there are some diseases that, if you are found to have them, must be reported to the health department.

First, I am going to ask you a couple of general questions about whether you've seen a doctor lately, and about where you live.

1. Have you seen a doctor or other health care provider in the past three months?
(yes / no)

2. a. Where have you been living? Ever on the street or in a shelter? (yes / no)

 b. Have you ever been in jail? (yes / no)

Now I want to ask you some specific questions about certain kinds of diseases. The reasons for these questions is that the diseases we're talking about are better treated if they are caught early.

You have probably heard about HIV and AIDS--that you can have it and not be sick. That's an example of the kinds of things we're looking for. It's much better to find out about it early, because treatment works better in early cases. [Women: "This is especially important if there is a chance that you could be pregnant, because your baby could get sick or die if you have HIV."]

3. Have you ever been told you have a positive test for HIV? (yes / no)

4. **Women:** Have you missed your last two periods? (yes / no)
5. Have you ever had a positive skin test for TB? I mean a test where they gave you a shot in your forearm, and a few days later a hard bump like a blister appeared. (yes / no)
6. Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year? (yes/ no)
7. a. Within the last 30 days, have you had any of the following symptoms lasting for more than two weeks?
 - fever
 - drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
 - coughing up blood
 - shortness of breath
 - lumps or swollen glands in the neck or armpits
 - losing weight without meaning to
 - diarrhea (runs) lasting more than a week
- b. Are you now living with someone with any of the following?
 - coughing up blood
 - drenching night sweats
 - active TB

8. Do you use needles to shoot drugs? (yes / no)

9. Do you use coke or crack? (yes / no)

I am going to ask you these next questions because, as you probably know, there are certain types of infections--like sexually transmitted diseases--that you can get from having sex with other people. Some of these questions are pretty personal, but you should know that I am not here to judge you. Don't worry about saying "yes" to any of these questions if that's the true answer. The only thing I am interested in is finding out if you're at risk for a disease that we can treat you for.

10. In the last six months, have you had any STDs (venereal diseases), like syphilis or bad blood, the clap (gonorrhea) or drip, chlamydia, or trichomoniasis? (yes / no)

11. Have you, or anyone you've had sex with, had any of the following symptoms within the last 30 days?

- a. sore or ulcer on the penis or vagina ("down there")
- b. rash or spots, especially on your palms or on the soles of your feet

Women:

- c. a vaginal discharge that is different from what you usually have
- d. pain when you have vaginal sex

Men:

- e. pus or drip discharge from the penis

12. Have you had sex with more than one person in the past six months? I mean any type of vaginal, rectal, or oral contact, like you went down on your partner or she/he went down on you, with or without a condom or dam?

13. Have you used your rectum (anus, bottom, butt, ass) or another person's for sex? (yes / no)

14. In the past six months, have you had sex with someone in return for anything, like money, alcohol or other drugs, a place to stay, or just to survive? (yes / no)

15. Have you ever been forced to have sex against your will? (yes / no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

NOTES:

Notes on the Screening Questions

1. This question is a lead-in intended to put the interviewee at ease.
- 2a. This question is asked because there is an increase in the incidence of TB among homeless individuals that is related to their crowded conditions and limited access to medical care. There have also been TB outbreaks in these settings.
- 2b. In certain jurisdictions, there is an increased risk of exposure to TB and HIV among individuals who have been incarcerated. This increased risk is related to crowded conditions (for TB) and to the common occurrence of sexual assault and unprotected sex among inmates. A positive response to this question should prompt referral of the individual for HIV testing and counseling in those jurisdictions where HIV is prevalent among prison inmates.
3. HIV-infected persons are at increased risk for TB and STDs. The individual's response to this question should be handled with sensitivity and care. Many HIV-positive individuals have not sought care because of lack of resources, fear of alienation from family and friends, or denial.
4. This question is intended to identify women who may be pregnant and who, in the setting of AOD abuse or infectious-disease outreach, have an increased risk of maternal-fetal transmission of syphilis or HIV.
5. This question is intended to identify individuals with latent TB who are, as a consequence, at risk for active TB. Although most individuals with positive TB skin tests do not have active TB. Individuals likely to be screened for AOD abuse and STDs and who have positive skin tests should be referred for evaluation to determine whether they have active TB or HIV infection or should receive preventive chemotherapy for TB. Some individuals with a positive skin test may have already been treated for TB prevention; however, it is recommended that a further history be taken by the TB facility to which the individual is referred.
6. This question is intended to identify individuals with TB who are not already in contact, or have fallen out of touch, with their treatment facility. It is also intended to identify individuals who have been in contact with someone who has TB and who thereby have an increased risk of developing latent or active TB. In the non-HIV infected population, the highest risk of developing active TB occurs within the first two years after exposure and infection. In the HIV-infected population, however, the high risk of developing active disease does *not* diminish dramatically with subsequent years and actually *increases* as HIV infection progresses to full-blown AIDS.
- 7a. Although the first four symptoms listed in this question are common among individuals with active TB, they are nonspecific and are also consistent with other diagnoses, including bacterial pneumonia, acute bronchitis, lung cancer, and HIV-related lung disease. Other symptoms include lumps or swollen glands in the neck or armpits, which may be present in individuals with extrapulmonary TB or AIDS-related conditions. Unintentional weight loss may identify individuals with latent or active TB or HIV infection; this is a very nonspecific symptom, however, and multiple other diagnoses are possible. Diarrhea lasting more than one week may be a sign of HIV infection but is also nonspecific.

7b. This question is intended to identify individuals who may be in contact with someone who has TB. These symptoms have been selected from those in Question 7a. as being somewhat more specific and more likely to indicate a high degree of infectious risk.

8. Injecting drug users are at highest risk for HIV infection, whether or not needle-sharing is acknowledged. In addition, these individuals are at increased epidemiologic risk for other STDs, TB, and hepatitis.

9. Cocaine and crack use has been linked to the presence of STDs, especially syphilis, and, in some parts of the United States, another genital-ulcer STD, chancroid. These diseases need specific treatment, are not easily diagnosed, and require that sexual contacts also be treated. Both the increased level of sexual activity associated with cocaine use and the presence of other STDs, such as syphilis, increase the risk of HIV infection.

10. A number of well-controlled studies have demonstrated that persons who have had an STD within the past six months are at risk for acquiring another STD. This supports the common-sense dictum that changing all aspects of sexual behavior is difficult, including increasing barrier protection, changing sex partner selection practices, and reducing the number of sexual partners.

11a. Genital sores could be symptoms of syphilis, herpes, condyloma, or chancroid, all of which are potentially serious STDs. Persons with genital ulcers are also at greater risk for HIV infection.

11b. Dermatologic symptoms are associated with secondary syphilis (especially in the case of rash on the soles and palms) or HIV infection, which is associated with a large number of skin conditions. It is important to differentiate these skin conditions from chronic skin conditions and from dermatologic manifestations of drug use (e.g., abscesses from skin popping).

11c. Although most STDs in women are asymptomatic, vaginal discharge can be indicative of gonorrhea, chlamydia, trichomoniasis, or other STDs. It can also, however, be a symptom of a yeast infection that is not an STD.

11d. Painful intercourse, or dyspareunia, especially abdominal pain associated with penetration or orgasm, may be a symptom of early pelvic inflammatory disease. This condition is an inflammation that may involve the fallopian tubes, uterus, and other pelvic structures and, if left untreated, can lead to infertility.

11e. Penile discharge is almost always a symptom of an STD. The discharge is usually persistent and may be associated, although not necessarily, with painful urination (dysuria). It usually represents either gonococcal urethritis (gonorrhea) or nongonococcal urethritis (NGU), which is often caused by chlamydia.

12. Having multiple sex partners is associated with an increased risk of STDs and HIV infection.

13. This question is especially important in assessing an individual's risk for HIV infection. Approximately 50% of men who have acquired HIV infection via male-to-male intercourse admit to this risk factor only after testing positive for HIV. The interviewer may need to talk about a male client's jail experiences in order to determine whether he has had active or receptive anal intercourse. Many men do not think of themselves as having "had sex" if they were raped by another man or if they had penetrative anal intercourse (forced or otherwise) with another man while incarcerated.
14. These activities are associated with an increased risk of STDs and HIV infection.
15. These activities are associated with an increased risk of STDs and HIV infection.

Simple Screening Instruments: AOD Abuse and Infectious Diseases

On the following pages there are details of the "profiles" of eight clients requesting services from an AOD abuse treatment program or a sexually transmitted disease clinic. Your task is to elicit information about an individual's substance abusing behavior or risk factors for infectious diseases.

Please read your assigned case and complete the following tasks.

1. Determine, for yourself, the issues that you believe are key to effectively eliciting information from the client.
2. Determine the risk factors for increased AOD abuse and/or infectious diseases presented by this client.
3. Arrive at some degree of group consensus on the top one or two issues and risk factors to be explored with this client. Then, select an initial technique for the interviewer to use.
4. On the following page take notes on how well the interviewer addressed the issues and factors previously identified. List those skills that helped the interview process and those which need improvement.
5. Provide feedback to the interviewer after completion of the roleplay.

| Effective Techniques | Techniques Needing Improvements |
|-----------------------------|--|
| | |

CASE STUDY #1

Counselor Information

Client Name: "AC"

"AC" is a 24 year old male, presenting with symptoms of gonorrhea. He states that he is a salesman and apparently "picked up this little problem" from one of several women he had sex with several weeks ago while on a trip through the South. He has been married for nearly six years but says he doesn't have sexual relations with his wife very often--"she's too busy and I'm too tired."

AC is concerned about his wife finding out about "the problem". He states that he hasn't had sex with her in nearly four months, so he knows he hasn't infected her. Plus, he says "the last time this happened, she hit the roof."

Client Information: "AC"

You are 24 years old and are at this public health clinic, presenting with symptoms of gonorrhea.

You are a salesman who travels through many of the mid-Atlantic and Southern States. You are pretty bored with work, but you do enjoy the social life: being in new towns with new faces. You don't consider yourself a "swinger" in any way but you do have regular women you have sex with when you travel.

You have been married for nearly six years. You and your wife seldom have sexual relations--"She's too busy and you are too tired..."

You don't think you have a drinking problem but your "beer belly" is starting to bother you. You almost always have had something to drink before you have sex. Five to six drinks per evening is typical.

You occasionally smoke marijuana but only if someone offers it. You never buy pot on your own. The same is true with cocaine. And your coke use is infrequent....once or twice a year.

You really don't want your wife to find out about "the problem....gonorrhea." You haven't had sex with your wife in nearly four months. Last time you had an "STD she hit the roof."

CASE STUDY #2

Counselor Information

Client Name. Kris

Kris is 26 and, having just completed a five-day detox program last week for alcohol, is in his first week of a 28-day rehab program. While alcohol has been his major drug of preference, he also reports snorting cocaine on occasion, usually with an older brother or with some gay friends.

Kris has told you that he has been sexually active since he was in junior high, having fathered a baby when he was 17. Lately though, he seems "burnt out" on the bar scene and all the hustling and game playing. He actually enjoys "being with my gay friends ... at least they're honest."

Client Information: Kris

You are 26 years old and have just completed a five-day detox program for alcohol use. You are currently in your first week of a 28-day rehab program. You have worked off and on at various 'quick printing services'-quite often the late night shift. A year or two ago, a co-worker gave you some coke to snort and you also snort ritalin. It helps keep you alert while at work.

Your "beer for breakfast" routine was helpful to get you to sleep-usually a six pack in the early morning. Your older brother and some gay friends often supply you with coke for an afternoon "pre-work" buzz.

You have been sexually active since you were in the ninth grade. You fathered a baby when you were 17, but the woman and your son moved away and you don't know where they are. You came into the detox because you were getting tired and burnt out with the bar scene and trying to meet people.

You have developed a number of good friends who are gay. You enjoy being with them "at least they are honest." And while not gay yourself, you have occasionally had sex with one of them. Usually mutual oral sex is what you enjoy.

CASE STUDY #3

Counselor Information

Client Name: TrayCee

TrayCee is back in this STD clinic for at least her third time in the past 12 months. On her previous visits, TrayCee was diagnosed with gonorrhea in her throat. She has previously been treated for rectal gonorrhea and chlamydia as well. You have discussed HIV testing with her. She just doesn't want to know "not now".

TrayCee has also told you that giving up sex "really ain't no possibility not right now."

Client Information: TrayCee

You are 21 years old and are at an STD clinic for the fourth time this year. You have been diagnosed with oral gonorrhea, rectal gonorrhea and chlamydia. You have taken the drugs the clinic staff provide until the symptoms are gone.

You started smoking crack cocaine last summer and you enjoy the high feelings and sex that accompany the drug use. You spend a lot of time at several crack dens often engaging in sex for drugs. Anything goes sexually if it means getting the drug.

You are anxious to get whatever tests and then treatments are necessary for this new clap problem. You don't want to hear about HIV testing, you just want to get out on the streets "where its happening".

You are convinced that giving up sex, right now, is not possible. No way...

CASE STUDY #4

Counselor Information

Client Name: Nathan

Nathan has been a patient in a methadone to abstinence program for nearly six months. He began shooting heroin and occasionally cocaine, several years ago. He has been working construction for the past six months. He asks to speak with you today- "it's something really important-" You faintly smell alcohol on his breath as he tells you that a former lover just tested positive for HIV. He also tells you that a year or so ago, a guy he knew when he was in jail, died from AIDS. Nathan wants to know what he should do.

Client Information: Nathan

You are 32 and in your sixth month of a methadone maintenance to abstinence program. You began shooting heroin three years ago. You occasionally shot cocaine as well.

Since you have been on methadone, you haven't used any illegal drugs. You drink a lot more beer and vodka, however. Your drinking is raising some eyebrows at the construction site where you work. People may think you have a problem you don't recognize.

You came in to talk with your counselor today because a former lover, a guy from your hometown, just told you that he tested positive for HIV. You and your friend enjoyed being together, and while sex wasn't the strongest part of your relationship, you guys did have mutual oral sex and anal sex once or twice, with you being the active partner (insertive) .

You were in jail for five months as a result of fighting and assaulting a police officer two years ago. A guy you knew in jail, and with whom you had sex, died from AIDS, You are here with the counselor to find out what you should do.

CASE STUDY #5

Counselor Information

Client Name: Leslie/"Precious"

"Precious" is 22, a cross-dresser "just waiting for the money and the okay to get my change"--a reference to a much desired sex change operation. Precious thinks she may have an STD since rectal burning and itching has been bothering her for a couple of days. She also has a "drip" from her penis.

Precious also asks if the drugs you may give her will take care of her cough and chills. "I picked up some bug from that damned shelter."

CASE STUDY #5

Client Information: Leslie/"Precious"

You are 22 years old. While biologically a man, you are waiting to get a sex change when you have enough money. You have been shooting hormones you get from "an older street queen" who has befriended you. You are in this STD clinic because you think you may have anal/rectal gonorrhea. You also have a drip from your penis.

You hustle sex for money and occasionally crack. You frequently have anal sex with guys hoping they don't find out you're really a guy. You also perform oral sex for the same reasons.

You have been living in a shelter off and on. You don't like the shelter people any more than they like you. Plus you think you get sick being there. You currently have chills and a very bad cough. You hope that whatever drugs they give you for the STD will get rid of the chills and cough as well.

CASE STUDY #6

Counselor Information

Client Name: Carter

This is Carter's second time through this 28-day rehab program. He relapsed four months after completing treatment for cocaine use. He says he is a heavy drinker, but "that's not my problem--I can't seem to stay away from the pipe."

His appearance has changed dramatically. In his first week back in the program, staff have commented on how he looks "burnt out". He has lost a fair amount of weight and his roommate has complained about Nathan's racking coughing fits at night.

CASE STUDY #6

Client Information: Carter

You are 26 and going through a 28-day rehab program for the second time. You have been a heavy drinker since high school and have been smoking crack for over a year. You are financially being ruined by the crack use. You recently thought about getting paid for sex just to keep the crack use.

You have lost about 20 pounds, weight you really couldn't afford to lose from your 6'2' frame. You have experienced night sweats and have a racking cough that wipes you out at night. But since it seems like every one is fighting the flu or colds, you think you'll be able to kick this any day now.

You have never been tested for any STD or other infectious disease.

CASE STUDY #7

Counselor Information

Client Name: LeeAnn

LeeAnn recently completed a 15-day rehab program and is seeing you weekly for individual sessions and twice-weekly for group sessions. LeeAnn has been smoking crack for several years. She has admitted to you that she often trades sex for crack.

She has told you about a close male friend who died from AIDS nearly two years ago. She has had a lot of STDs. In group meetings, LeeAnn talks often about the pull of the sexual activity and the crack use. You have concerns about LeeAnn staying clean and sober.

Client Information: LeeAnn

You are 24 and, having completed a 15-day rehab program, are currently being seen in outpatient treatment, both in individual counseling and in a group setting. After completing high school, you got involved with a man who at the time was 31 years old. It was through this connection to him that you first became heavily involved in cocaine and heroin use, usually injecting. Almost two years ago this man died of complications from AIDS and liver cancer. You stopped using drugs for six weeks after his death, then got turned on to smoking crack. Sex for drugs has been a way of life for the past eight months. You have had numerous STDs and recently were told you have chronic hepatitis C. You have never been tested for HIV. You have also been experiencing swelling and soreness in your lower abdomen.

ASSISTING CLIENTS TO PERSONALIZE THEIR RISK

Many of the infectious diseases as well as AOD abuse are behaviorally focused. An important goal for treatment counselors and disease intervention specialists is to have clients personalize their risks and hopefully, change their behaviors. After brief screening interviews, a client should receive information on infectious diseases and alcohol/other drug abuse. This still may not be enough to alter a person's behaviors. We know that information alone isn't enough. Individuals need to change attitudes as well.

The following risk assessment and harm reduction tool helps an individual to "own" her/his personal behaviors that place her/him at very real risk. For the risk assessment to accomplish this personalization and attitudinal change, we must address certain **content**, using **effective skills**, and a **process** that actively involves the client.

Personalizing Risk: Content

To help a client personalize risk, the risk assessment actively involves her/him in assessing her/his:

- ✓ beliefs about the modes of disease infection;
- ✓ use of AOD, including sharing drug injection equipment;
- ✓ unsafe sexual activity;
- ✓ other exposures to potentially contaminated blood products, semen or equipment;
- ✓ involvement in the above activities in or with people from locations of high levels of infectious disease; and
- ✓ physical symptoms that may be related to AOD use and infectious diseases.

PERSONALIZING ONE'S RISK FOR HIV DISEASE

| Potential For Infection | TRANSMISSION FACTORS | | | | TALLY | RISK REDUCTION PRACTICES | | Potential For Risk Reduction |
|-------------------------|--|---|--|--|-------|---|--|--|
| | Fluid Type | Route of Absorption | Fluid Dose | Health Status | | Sexual Activities | IV Drug Use/ Other Needle Practices | |
| HIGH RISK | Blood Semen Vaginal/ Cervical secretions | Injection Rectum Vagina Placenta | Large volume Repeated exposures | Infected with other agents | III | Douching Sharing works No protection | Judgement-imparing substance use | Not Effective |
| | Breastmilk | Break in skin Penis Mouth | Occasional exposures Stressed Pregnant | Malnourished Drug use (including alcohol and tobacco) | | Withdrawal Reducing # of partners | No precautions | |
| | Saliva Tears Urine | Newly inflicted wound Eyes Nose | Small volume One exposure | Healthy | | Using condoms (w/out spermicide) Using condoms with spermicide | Disinfecting works Using only one's own works | Disinfecting wounds Handwashing Wearing gloves when handling bodily fluids |
| | Sweat Feces | Intact skin | No exposure | | | Non-penetrating sexual stimulation | Using only new or sterilized needles Abstinence | Proper waste disposal Abstinence |
| NO RISK | | | | | | | Disinfecting reusables/spills | Fully Effective |

*The following section refers to the **chart** Personalizing One's Risk for HIV Disease.*

Process

The left-hand side of the **chart** is suggested as a valuable guide to the risk assessment process. As a "third-party" on which to focus discussion, it can help to ease some of the personal discomfort that we experience with sexual or drug-taking activities. Further, this chart is designed for use by the client, thereby increasing the kind of active involvement in the assessment that is needed to achieve risk personalization.

Before initiating the steps of the risk assessment process listed below, you will want to set up the interview to provide for your client's needs for privacy and confidentiality. You can then proceed through the series of steps at your client's pace--perhaps over a number of meetings, when possible--to accommodate her/his individual ability to absorb the implications of the assessment.

1. Explain the purpose of the risk assessment.
2. Ask client to explain what she/he believes about the three major modes of risk:
 - a. sharing of injection works
 - b. unsafe sexual practices
 - c. other exposures to blood/blood products/semen
3. Ask client to assess her/his injection works-sharing history:
 - a. direct client to circle appropriate items under each of the first three factor categories;
 - b. direct client to circle appropriate items under "Health Status" category;
 - c. identifying any increased risk factors--sharing works in or with people from areas of high HIV/AIDS incidence.
4. Ask client to assess her/his unsafe sex history:
 - a. for all appropriate practices in succession
 - anal intercourse, "insertive" and/or "receptive"
 - vaginal intercourse, insertive or receptive and during menses
 - oral-genital/oral-anal contacts
 - masturbating someone else
 - sharing of "sex toys";

5. Ask client to assess her/his exposure to blood/blood products/semen:

- a. for appropriate practices in succession
 - tattooing and/or scarification
 - transfusion and/or hemophilia treatments
 - artificial insemination.

Note: Risk for urine, feces, and saliva vary for other infectious diseases and should be assessed and reviewed with clients when appropriate.

- 6. Ask client to review her/his circled items and for all risk practices select an "average" for the tally column. Discuss concerns or feelings.
- 7. Ask client to review any sexually transmitted or infectious diseases they have had in the recent past. Presence of these diseases may indicate behavioral vulnerability for HIV disease. It can also make a body more susceptible to infection or disease progression.
- 8. Bridge to risk reduction planning.

NOTES:

Skills

Encouraging someone to discuss her/his personal risks for infectious disease or substance abuse can be a challenge. We have already discussed some of the attitudinal barriers which could hinder our assessment. Below, list some areas of discomfort that your clients may experience in engaging in a risk assessment.

Considering these areas of potential client discomfort, what **skills** can we as counselors bring to risk assessment to increase client comfort and active involvement?

Review your list of skills. Consider how many you use regularly in counseling AOD clients or infectious diseases patients. Many of us are surprised to find that risk-assessment work is less a matter of learning new skills than it is of adapting already existing and fine-tuned techniques to address other issues.

Practicum

Now that we have reviewed the content, skills, and a process for risk assessment, you will have a chance to practice a typical session. Using one of the case scenarios on the following pages, you will conduct a roleplay with two other colleagues.

The **counselor or interviewer** is to engage the **client** in an assessment of her/his risk(s) of infectious disease as well as current AOD abuse. The **Scorecard** is available as a tool to assist in the process. The third person on your team is responsible for observing the interaction and leading a discussion based on the following questions after completion of the role play.

1. What **content** components of a risk assessment were addressed? How completely was each addressed?
2. What **skills** did the counselor/interviewer use during the risk assessment? Which were particularly effective? Why?
3. When was the client most receptive to/actively involved in the interview? Why?
4. What would you recommend the counselor/interviewer to do in the future to improve the effectiveness of the risk assessment?

Personalizing Risk: Harm Reduction

Having assisted a client to assess her/his risk, we can now build effective behavior change by helping clients to:

- ✓ identify appropriate practices for reducing their level of risk;
- ✓ negotiate and plan individually selected changes; and
- ✓ reinforce and sustain the changes initiated.

Risk-free behavior will not "come together" overnight. Harm reduction is a process, one that varies from client to client. Harm reduction counseling will need to vary accordingly.

Content and Process

Both the content and process for conducting harm-reduction counseling are contained in a step-wise use of the right-hand side of the **Personalizing Risk CHART**.

1. Explain the purpose of harm-reduction counseling.
2. Ask the client to:
 - a. restate her/his assessed risks of infectious diseases and types of AOD use;
 - b. describe her/his understanding of harm reduction.
3. Focus on the sexual harm reduction category, and:
 - a. describe the increasingly protective practices;
 - b. have the client circle changes already made; and
 - c. negotiate, as needed, selection of a more effective harm-reduction practice.
4. Discuss, demonstrate, plan and rehearse the change.
5. Focus on the second category, and repeat steps three and four.
6. Finalize change plan with first actions to be taken.

Harm Reduction Skills

Changes in sexual and addictive behaviors are among the most difficult to make. Reflecting back to personal experiences you have had with behavior change, recall what helped you get started once you had made the decision to change, and what helped you overcome obstacles and keep going.

Can you think of counseling skills that might provide similar help to your clients in reducing risk? List below some of the skills that you and your colleagues believe are critical to negotiating, planning and sustaining behavior change.

NOTES:

Harm Reduction Practicum

The objective of this harm-reduction session roleplay is to negotiate behavior change that will reduce the assessed levels of risk. This role play will also include demonstrating and rehearsing the identified changes as needed with the client.

You will roleplay the harm-reduction counseling session using a "round-robin" approach with several other counselors. Each "counselor" will have a few minutes to negotiate with the assigned "client" as several other participants observe. The **Personalizing Risk CHART** is available to assist you in describing the array of harm-reduction practices and in helping the client plan which are appropriate for her/him to adopt.

Upon completion of the practicum, discuss the following in your group:

1. Which harm-reduction practices were addressed in the roleplay?
2. What skills used by "counselors" appeared successful in harm-reduction planning?
3. Where did the client appear to get stuck?
4. How did/might the counselor help the client get "unstuck"?

Unit 5

Legal Issues Surrounding Confidentiality: Collaborating in the Provision of Communicable Disease Treatment

Perceived Obstacles to Maintaining Confidentiality

In an effort to control, prevent or treat the spread of communicable diseases, all States require health care providers and sometimes others to report cases of communicable disease to local public health authorities. These reports enable public health officials to locate, examine, counsel, treat, and monitor anyone presenting with a communicable disease. These mandated reporting requirements may appear to conflict with the Federal confidentiality regulations for drug and alcohol records which restrict patient-identifying disclosures about individuals in AOD treatment.

Laws and regulations that govern communication about clients and protect their confidentiality are sometimes viewed as an irritation or a barrier to achieving public health or AOD program goals. For example, some staff may view as burdensome the requirement that a client must sign a consent form before providing services for that client.

The process of obtaining consent, however, can also be seen as a small ceremony that provides a way of making a contract with the client. The worker is about to perform services for the client, and the client should begin to view seriously her or his part of the bargain in following up.

Moreover, it is at this point that AOD treatment staff can let the client know that workers and programs, as well as other people interested in providing health care-related services, take her or his privacy very seriously.

Most of the problems that may arise under the State and Federal laws and regulations that protect clients' confidentiality can easily be avoided through planning ahead. Familiarity with the rules will ease communication and can also limit confidentiality-related conflicts between the program, the client and outside agencies.

Collaboration and cooperation can benefit clients as well as the AOD treatment goals and public health concerns. This is particularly true with respect to cases of tuberculosis, which, unlike some other communicable diseases, can be spread by casual contact.

The contents of this section have been adapted from two CSAT publications:

Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases, Chapter 5 "Legal Issues Surrounding Client Confidentiality"; and

Confidentiality of Patient Records for Alcohol and Other Drug Treatment, Chapter 2 "Confidentiality of Alcohol and Other Drug Treatment Records and Communicable Disease: Options for Successful Communication and Collaboration"

CONFIDENTIALITY OF DRUG AND ALCOHOL PATIENT INFORMATION
(42 U.S.C. § 290dd-2; 42 C.F.R. Part 2)

THE GENERAL RULE:

The program may not disclose any information about any patient

Exceptions: Conditions permitting disclosures

- Internal Communications
- No patient identifying information
- Proper Consent
- Qualified Service Organization Agreement
- Medical Emergency
- Research/Audit
- Court Order
- Crime on program premises or against program personnel
- Reporting suspected child abuse and neglect

Proper Form

1. name of program
2. name of recipient
3. name of patient
4. purpose/need
5. extent/nature
6. revocation statement
7. expiration
8. signature of patient
9. date

Written Notice of
Prohibition on Redisclosure

Public Health Activities with Respect to Communicable Disease

Alcohol and other drug programs need to understand what it is that public health officials (and other health care providers) may want or need to do in response to a communicable disease case report. At the least, public health officials want or need to:

- **identify an actual or suspected case of communicable disease;**
- **verify the case by examination;**
- **counsel the infected patient with an eye toward preventing further transmission;**
- **prescribe appropriate treatment;**
- **locate contacts or trace partners for purposes of identifying other cases and preventing further transmission;**
- **monitor treatment for efficacy and compliance; and**
- **identify the nonadherent or noncooperative patient for purposes of invoking either civil or criminal sanctions.**

An appreciation of these activities will enable programs to ascertain exactly what information is needed for which public health purpose or activity and which of the available exceptions to the confidentiality regulations best fits the situation.

How Programs Can Comply with Communicable Disease Reporting Requirements

Reporting with Patient Consent

The easiest way for an AOD program to comply with State-mandated communicable disease reporting and follow up requirements is for the program to secure the patient's consent to both the mandated report and follow up activities. Such a consent can be put in place at intake or screening, with periodic renewals as necessary. Depending on State law, the consent can be made to last for as long as the patient is in the program. (However, some States have laws that limit the validity of releases and consents to no more than 60 or 90 days. In such States, a consent would have to be renewed at the appropriate juncture.)

Given a proper consent, a program may report nearly anything the patient authorizes it to report, including the patient's state of health and whereabouts. The ability to report the patient's whereabouts is especially important in the case of patients who must be examined without delay, for example, patients with suspected tuberculosis (something that is almost always problematic for patients in residential treatment, since, by definition, a disclosure of a residential treatment patient's address is patient identifying).

Moreover, a consent, unlike some other exceptions, can allow for the redisclosure of patient-identifying information. This is particularly important where different public health officials need to communicate with one another or other health care providers for purposes of tracking and controlling disease.

The two drawbacks to the consent option, at least from the view of public health, are that a consent may be withdrawn at will by the patient, and that a consent may not be the basis for imposing criminal sanctions on a noncompliant patient or a patient who engages in risky behavior. Only a **court order** may authorize the imposition of such sanctions against a noncompliant or risk-taking patient.

Reporting "Anonymously"

An AOD treatment program could conceivably discharge its State-mandated disease reporting obligations by making anonymous or non-patient identifying disclosures. Under this exception, a program is allowed, for example, to disclose a patient's name and state of health and even his or her whereabouts as long as in doing so it does not also disclose that the client is in substance abuse treatment. Notwithstanding its apparent attractions, there are problems with a program's electing to rely on this exception to discharge its disease reporting or follow up obligations.

The most obvious of these has to do with the fact that most States require reporters to identify themselves. Obviously, a freestanding or residential treatment program would not be able to comply with an identification requirement without giving itself and the patient away.

A second problem arises where the recipient of the disclosure--here, a public health agency--wishes to establish ongoing communication with the program for the purpose of identifying and locating individuals who may have come in contact with, say, an AOD patient who is suspected of having TB. Under the circumstances, a program would not be able to cooperate with public health officials in locating, examining, counseling, educating, treating, or monitoring such contacts, since, in all likelihood, such cooperation would result in impermissible disclosures.

Reporting by Use of a Qualified Service Organization Agreement

Programs that are required to make communicable disease case reports to local public health officials may comply with their reporting obligations by entering a qualified service organization agreement (QSOA) with an outside agency or individual (the qualified service organization). This mechanism authorizes ongoing communications between the program and an outside agency involved in treating or monitoring a patient's care.

Thus, an AOD treatment program can enter a QSOA with an outside medical care provider who would agree to provide screening and treatment to the program's clients and make mandated communicable disease reports to the State or local public health authorities. Such an arrangement would enable the AOD program and the outside service organization to share information (including AOD patient-identifying information) without first obtaining individual patient consents.

However, in making mandated reports to public health officials, the outside service provider would be forbidden from disclosing any AOD patient-identifying information, unless the redisclosure was authorized by consent or by one of the other exceptions under the regulations.

Depending on the nature of the qualified service organization, this arrangement probably would not permit the program to cooperate with local public health officials in following up on a given communicable disease report. The program could overcome this problem by entering a QSOA directly with the State or local public health officials responsible for conducting communicable disease prevention, treatment and control activities. A QSOA between an AOD program and a public health agency would open a channel of communication between the two that would permit the former to make mandated reports and allow the latter to follow up any such reports to the degree necessary.

AOD programs are not required to obtain patient consent prior to entering a QSOA, nor need they inform patients of the QSOAs to which they are a party. Naturally, to the extent that a patient or client, (who, after all, proceeds with the assurance that her or his records are confidential) is surprised by a given QSOA, her or his confidence in the program or her or his counselor may be undermined. It is probably in a program's best interest to inform its patients of existing or proposed QSOAs.

Reporting and Follow-up Under the Medical-Emergency Exception

Under the medical-emergency exception, a program may disclose patient-identifying information to medical personnel in a medical emergency that requires immediate medical intervention. Under this rather narrow exception (which requires a **case-by-case decision** as to whether a threat exists or immediate medical intervention is required), a program could report a communicable disease to public health officials only if the following conditions are met:

- **the presence of an infected or allegedly infected individual in the program could be said to constitute a medical emergency, or,**
- **public health officials are medical personnel.**

Under the regulations, a medical emergency is a situation that requires immediate medical intervention. Generally, sexually transmitted diseases and HIV/AIDS, though communicable, are not emergencies because they do not pose immediate threats to life.

The situation is different with TB or suspected TB. Because TB is transmitted by casual contact, it is difficult to confirm, and is potentially deadly, the presence of a suspected case of TB in an AOD treatment program may very well constitute the sort of emergency that can be reported to public health officials under the medical-emergency exception to the regulations. For the same reasons, it may also be that a suspected or confirmed case of TB will permit a program to make the required report to public health officials but also to cooperate with them in their follow up activities.

Options for Communicating and Collaborating in the Provision of Communicable Disease Treatment, Monitoring and Follow up:

What is Possible?

It is up to each program to decide what is the best or most apt exception for purposes of meeting State public health reporting requirements. Perhaps in an ideal world programs and patients/clients would both agree to put in place appropriate consents that would allow programs to comply with all their public health obligations. Yet consents are not without their drawbacks. The most important of these drawbacks is that consents can be withdrawn at will. To be sure, a program might counter the revocation of a consent by making treatment contingent on a new consent (whether a program can do this depends on State law), but such a move--insinuating coercion, as it does--would not be without costs and could damage the therapeutic relationship.

Another option would be to put in place a QSOA with the local public health agency. This would permit the program to comply with both reporting and follow up obligations. Since a program is not obligated to inform a client of the existence of a QSOA, this option may also be considered to have the added advantage of making the QSOA appear to be a standard element of the program.

With regard to TB or suspected TB, an AOD program can probably rely on the medical-emergency exception to make a report.

Unit 6

Developing Plans to Link Clients to Treatment Services

Development of this cross-training workshop was motivated by individuals at CSAT and CDC who recognized the need for service providers from a variety of agencies to learn more about the similarities of infectious diseases and the disease of addiction. It is hoped that a climate for cooperation has been created or maintained by bringing personnel from the various disciplines and departments together to learn common screening, risk assessment and harm reduction skills.

This last section of the course will focus on a personal assessment of your ability to use the information and skills when you return to your agency.

At Work Application

Describe situations in which you plan to apply the information and skills learned in this workshop. Please state when and how you plan to apply it. Be specific.

I. The Alcohol and Other Drug Abuse/Infectious Disease Connection

Implementation Goals

Situation:

My plan to apply:

II. An Overview of Alcohol and Other Drug Use

Implementation Goals

Situation:

My plan to apply:

III. An Overview of STDs, TB and Other Infectious Diseases

Implementation Goals

Situation:

My plan to apply:

IV. Screening and Assessment Methods

Implementation Goals

Situation:

My plan to apply:

V. Legal Issues Surrounding Confidentiality

Implementation Goals

Situation:

My plan to apply:

Self-assessment

Take a few moments and answer the following questions related to the information and skills shared during this cross-training workshop.

Of the information that was presented, I am still least clear about:

Of the skills demonstrated and practiced, I feel less certain about my ability to:

Other skills and information I need as I begin implementing components of this workshop include:

Is there someone in your agency, community or in this training workshop who has knowledge or skills which might help you increase your abilities to implement components of this workshop?

Is there a particular skill or body of knowledge you could learn more about by reading?

Are there other courses, workshops, seminars, conferences you could attend to assist your development?

Making Referrals: the Final Link

As we have discussed, collaboration between experts in AOD and infectious diseases is essential in combating the epidemics of HIV, TB and addiction.

Take notes as workshop participants discuss how referrals are made to particular agencies.

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